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ORIGINAL DEPARTMENT.

LECTURE.

VAGINAL FISTULES.

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This morning we will consider the classification of fistulous communications with the vagina, together with the symptoms, diagnosis, etiology and treatment.

We may have vesico-uterine fistules, vesico-utero-vaginal fistules, vesico-vaginal, urethro-vaginal, recto-vaginal and perineo-vaginal fistules; also uretero-vaginal and uretero-uterine fistules.

A knowledge of vaginal fistules is of much greater importance to the practitioner now than formerly, from the fact that with the present improved methods of operating we can, in nearly every instance, permanently relieve these patients, and bring about a restoration of the natural condition, without impairing to any great extent the function of copulation and reproduction. The symptoms of these fistulous openings are usually sufficiently diagnostic to enable us to diagnose that there is a communication from some of the adjacent pelvic organs connecting with the vagina; but the subjective symptoms are not pathognomonic, nor are they sufficiently diagnostic to enable us to say from where the particular opening enters into the vagina. The most important of all the symptoms is either a discharge from the vagina of urine or fecal matter, the latter of which is pathognomonic of recto-

vaginal fistule. But with the former this is not the case, for we may have a constant passing of urine from the vulva, so that the bladder is kept empty, when there is no fistulous opening connecting the bladder with the vagina, the condition being simply the result of inability on the part of the woman to retain her urine, and it dribbles away through its natural channel. These are most of the subjective symptoms that your attention will be called to. The dribbling of urine or the passage of feces from the vagina may begin immediately after labor, or more usually not until the third to the tenth day, and then it continues constantly, until the fistule is cured.

It is unnecessary to call attention to the great annoyance and inconvenience that result from the constant passage of urine or fecal matter through the vagina, so I will now pass on to the diagnosis of the fistulous openings by a physical examination. By availing ourselves of the objective symptoms, we can usually arrive at an accurate diagnosis with but little difficulty. Where the opening is large and connects directly with the vagina, by a digital examination we will be able to ascertain its locality and dimensions. Where the opening is small and connects directly with the vagina, whether a vesico-vaginal, urethro-vaginal, recto-vaginal, or perineo-vaginal fistule, we can detect usually a little elevation that marks the position of the opening. But where it is a uretero-uterine fistule, or where the cervix uteri is involved, we will very often experience considerable difficulty in completing the diagnosis. Where we are not able to make the diagnosis by digital examination, we may combine with it an instrumental examination. By the use of the finger in the

vagina and the sound in the bladder we may be able to bring the sound through the opening into the vagina, against the finger. Or, with the finger in the rectum, and a sound in the vagina, we may be able to diagnose an opening between the rectum and the vagina. Or we may expose the vagina with Sims' speculum, so as to see the entire vaginal surface, and detect by this means the opening in the vagina. Every part of the vaginal surface can be exposed where the vagina is not contracted and misshapen by cicatricial bands, and in this we may be able to see the opening of the slightest fistule. Now when we are unable to make the diagnosis by the combined digital and instrumental examination, we fortunately have other means at our disposal. We may inject the bladder or the rectum with colored water, and by having the vagina exposed and reflecting light into it, we can see where this colored liquid comes through the smallest-sized fistulous opening. If it is in the anterior vaginal wall or the regular vesico-vaginal fistule, we can see the colored liquid coming through, drop by drop, in that locality. If it be a vesico-utero-vaginal fistule where the opening comes from the bladder into the neck of the uterus and down through its tissue, we will see, usually, just at the anterior edge of the cervix, the colored liquid dripping down into the vagina. If it be a vesico-uterine fistule, where the opening connects from the bladder above the vaginal attachment into the cervical cavity, we will find the liquid coming down into the vagina through the cervical canal. But where it is a uretero-vaginal or a uretero-uterine fistule, then we cannot make the diagnosis in this way, and about the only means of doing so is by the exclusion of the other varieties. When we find that the urine constantly dribbles away, and by no means at our disposal are we able to find any communication between the vagina or uterus with the bladder, then by exclusion we could diagnose a uretero-vaginal or uretero-uterine fistule.

The idea prevails largely with the general profession, that fistulous communications with the vagina generally result from instrumental interference in labor; but the investigations of leading gynecologists have now conclusively demonstrated that, so far from this being true, the timely use of instruments to speedily deliver the woman often prevents sloughing, and consequently fistulous openings. Practically speaking, fistules resulting from other causes than labor are of little interest to the physician; however, we may meet with occasional fistules caused by cancerous, syphilitic

or other forms of ulceration, or from whatever may penetrate through the walls of the vagina into an adjacent viscus.

The fistules caused during labor result from the pressure sustained by the parts between the bony structures of the mother and the head of the child, the pressure being so great that the circulation is cut off for a sufficient length of time to cause death of the parts; which, of course, is followed by a slough. As long as the child's head recedes after each pain there is comparatively little danger of serious injury to the maternal structures, but when the resiliency of the parts has been so destroyed that there is no recession of the child's head, then there is great danger of serious lesions, and unless the labor is promptly terminated there will almost invariably result a fistulous opening. A distended bladder may be the cause of a fistule, by obstructing the passage of the child and retarding the labor. It is at least a too frequent cause of vesico-vaginal fistule, and it is unfortunate that the general profession pays too little attention to emptying the bladder during labor. True, owing to the extreme pressure, it is sometimes next to impossible to introduce a catheter; but this difficulty can usually be overcome. If it cannot, it is much better that the child's head should be removed from its impacted condition against the urethra, by the use of the forceps, and if this be impossible, to even aspirate the bladder immediately above the pubes, than to allow it to remain distended. It may be observed that in those cases where the forceps has been used the women have been in labor much longer than in cases where the delivery is effected by the efforts of nature. It may be further stated that in those cases resulting after the use of forceps the destruction has been less than in those where no instrumental interference has been resorted to. The duration of the labor may, in general terms, be said not to affect the degree of the injury.

The urine may pass immediately after the passage of the child's head through the vulva. This is particularly true of cases resulting from a distended bladder, either caused from laceration or sloughing. In the majority of instances there is no passage of urine through the vagina until from two or three to ten days after labor. The majority of all cases of vaginal fistules occur in the primipara.

The history of vaginal fistules, we find, until quite recently, presents few successful operations for this distressing malady.

We find that a German physician, about 200

years ago, called the attention of the profession to the treatment of these fistules, and described the methods of examination and the operation for their cure, but it passed out of the knowledge of the profession, and nothing more was heard of the successful treatment of them until 1829, when Dr. H. S. Levert, of Mobile, Ala., in the May-No. of the *American Journal of Medical Sciences*, called attention to the use of the silver suture in the treatment of vaginal fistules. In November, 1834, M. M. Gosset, in a letter to the London *Lancet*, called attention to the successful operation for a vesico-vaginal fistule, the result of impaction of a stone in the bladder, in which he united the edges of the fistule by the interrupted silver suture. We find, then, that Neetzel, of Germany, in 1846, describes the clamp suture and the method of denuding the tissues by the bistoury or scissors, and speaks of a speculum essentially the same as that devised by Sims. We find, again, that between 1836 and 1840, Hayward, of Boston, had succeeded with the silk suture. Also, in 1847, that Dr. Mettauer, of Virginia, called attention to a successful operation by the use of lead sutures; but these successful operations were not brought prominently before the profession in this or any country, until the time of Dr. Sims, who, in the *American Journal of Medical Sciences*, in 1852, first published to the world his successful operations with the metallic sutures, claiming that nearly every case of fistule into the vagina can be permanently relieved by properly denuding the edges and bringing them together with silver sutures. He first used the clamp suture, but subsequently abandoned this method and united the edges by the interrupted silver suture. Whether Sims was familiar with the views of those who preceded him or not, he certainly deserves the greatest praise for having brought this operation so prominently before the profession that it is now considered one of the successful operations in surgery, instead of being almost invariably ignored or condemned, as in the past. The question has been discussed very freely by the profession, whether the success of the operation is due to the metallic suture or to some other cause.

Dr. Sims' belief was that before the time of his introduction of the metallic suture into practice, the reason of the failure of previous operations was because the organic suture caused suppuration in its track, thereby preventing the union of the denuded edges. It has now been proven that whether we use organic or metallic sutures the operation may be almost equally successful, and it has been conclusively demon-

strated that the success of the operation depends not so much upon the quality of the suture as upon the preparatory treatment, and the method of denuding the edges and bringing them properly together. There has been really very little improvement in the methods of performing the operation since Sims first published his researches, and he has written but little on this subject since. The treatment advised by Sims, and generally followed, is to thoroughly denude the edges of the fistule and bring them together with the intercepted silver suture, twisted tight enough to cause perfect coaptation, but not suppurative by strangulation. The patient must then be kept perfectly quiet, with the bowels bound, having the urine passed through a sigmoid, or some form of self-retaining catheter, with the woman in a horizontal position for ten or twelve days. These have been considered prerequisites to success in every instance; but we find that Prof. Simon, of Heidelberg, operates by bringing the edges together with the silk suture, and permits the patient to walk about, allows the urine to be passed as usual, as if no operation had been performed. He has achieved a wonderful success. He stands, however, nearly alone in his treatment. I myself doubt whether the custom of confining these patients to bed and having the water drawn by the catheter and the bowels bound is any better than his method. I would, in any event, after introducing a self-retaining catheter, adopt Prof. Simon's practice of not confining the patient to bed. Some operators do not even permit the patient to turn upon her side. A case upon which I operated some fifteen months ago was one of the most unfavorable that could be imagined. After the operation, the edges being united by twelve sutures, the woman was constantly nauseated and attempting to vomit; finally had severe spasms for thirty six hours. In the course of the third day she got out of bed and walked around the room. She made a perfect recovery.

One of the greatest improvements in the treatment of fistules is the preparatory treatment, which was first recommended and practiced by Dr. Sims and Dr. Bozeman—more efficiently by Bozeman. It has been my experience that if thorough preparatory treatment be practiced and the patient brought into a fit condition to be operated upon, it matters little, if the edges be well denuded, whether they be brought together by metallic or thread sutures; whether the woman be confined to bed or allowed to walk about the room; whether she wear a catheter constantly or have the urine regularly drawn; or

whether it be permitted to pass at will; whether the bowels move daily, or be purposely confined; you will have a successful result. There is more credit due him who has devised and popularized this preparatory treatment than to those who have suggested the suture, and the other advantages of operating. This preparatory treatment should be resorted to in nearly every instance, so as to remove every condition that may be detrimental to success.

We find in vesico-vaginal fistule, that the vagina and vulva are often in an inflamed and excoriated condition; that there are often phosphatic deposits within the vagina and upon the vulva; and if the fistulous opening is large the mucous membrane of the bladder may protrude in an unhealthy condition; that frequently the vaginal walls are indurated, and bear cicatricial bands, causing great contraction. Now, if the operation be performed while these conditions exist, it will almost invariably result in a failure, while if, by the preparatory treatment, the vagina be brought into a healthy condition, success will usually follow. It should be thoroughly washed out twice daily, with hot water, and all the phosphatic deposits which may have accumulated cleared away. Should the warm water fail to accomplish this we should touch each deposit with a weak solution of nitrate of silver; should the mucous membrane of the bladder protrude into the vagina in an inflamed condition, it may also, occasionally, receive the same application. Following this, the excoriated parts should be regularly anointed with some soothing unguent, to protect the raw surfaces from the irritation of the urine which is constantly dribbling over them. We usually, in these cases, find the urine phosphatic, and this condition may be best remedied by the administration of benzoic acid and borate of soda in doses sufficiently large to be diminished to such an amount as will keep the urine acid.

If there be cicatricial bands in the vagina they must be removed by nipping them with a pair of blunt pointed scissors, using the finger as a guide, care being taken not to cut through into Douglas' *cul-de-sac* posteriorly, nor into the bladder anteriorly. This process may cause profuse hemorrhage, but this can be controlled by the ordinary hæmostatics, or by the introduction of Sims' vaginal dilator, which must not be too tight, lest it cause injury by cutting off the circulation, and the consequent production of a slough. It may be held in position by a T bandage, and should not be removed until the

parts around it begin to suppurate, and then the vagina should be washed out, once or twice a day, with carbolized hot water. In the course of a week the wounds will have healed, and the parts will then generally be in a soft, healthy condition. However, if bands are still left, we should continue to divide them until the vagina is in a healthy condition. When this is accomplished, we are prepared to operate with good assurances of success. We will find that the edges of the fistule can then be brought together and easily coaptated, and, when united, they will hold together without any difficulty. If we operate without this preparatory treatment, we must bring together diseased cicatricial tissues, which are inelastic and continually maintain the parts upon the stretch, and frequently tear the parts asunder. These cicatricial bands having been removed, the edges of the fistule will readily come together, unless it be a fistulous opening that has been attended with an immense deal of sloughing of the septum.

The patient now being prepared, her bowels should first be moved by some gentle cathartic, and just before the operation, by an enema. Although it is customary to give chloroform, yet we can operate upon many cases by administering simply a full dose of opium or morphine long enough before the operation to have its full effects induced. In this country the patient is generally placed upon the left side, in what is known as Sims' position. Prof. Simon operates with the patient in the exaggerated lithotomy position; Bozeman in the knee-elbow position. We generally use Sims' speculum, or some modification of it; Bozeman uses a self-retaining speculum which he himself devised. Select, however, that which suits your purpose best, and you will probably prefer some form of Sims'. Three assistants will be necessary; four if we give an anæsthetic.

Now, with the parts thoroughly exposed, we catch the mucous membrane on the edges of the fistule with a tenaculum, and with the knife, or variously curved scissors, begin denuding the surface. By a little pains and some dexterity we will find ourselves able to take out the mucous membrane all around the openings in one continuous piece. This denudation should be carried out nearly half an inch upon the vaginal tissue, and should come down only to the mucous membrane of the bladder. Prof. Simon cuts deeply into the cystic mucous membrane, but there seems to be no necessity for invading this tissue, and, besides, when we do so, there is danger of profuse hemorrhage, one or two instances being on

record where such practice has been followed by a fatal result from this cause. The late Dr. Peaslee, of New York, recorded one such case. The edges being now thoroughly denuded, the sutures are introduced, and they are brought together. These should be, if possible, introduced so that the resultant cicatrix will extend in a longitudinal direction, in order not to shorten the vaginal wall, and thus displace the uterus: They should be introduced half an inch away from the denuded surface and carried down and out, just at the cystic mucous membrane, bringing them out at a corresponding distance on the opposite side; a distance of an eighth to a fourth of an inch apart will enable us to bring the edges perfectly together.

After the hemorrhage has all ceased, each suture, being drawn sufficiently tight, should be twisted and cut off, leaving about half an inch, which should then be doubled down upon itself. This being done, with a probe we should press down on every point between the sutures, to determine if any part be imperfectly coaptated. In order to determine this more accurately, we may inject the bladder or the rectum with colored water, when, if any be passed into the vagina, an additional suture must be introduced at that point where the opening appears.

The operation being completed, place your patient in bed, and introduce a self-retaining catheter, either Sims' sigmoid or Skene's modification of Goodman's, the latter of which I prefer. With this in position the patient may get up and walk about at any time after the operation. Permit the bowels to move daily, neither purging nor allowing constipation to exist. Give good, nourishing, and easily digested diet, not stimulating diet, and if called for, opiates, to relieve pain. After the tenth day remove the sutures, being careful and gentle, otherwise you may separate the union that has occurred. Let the patient continue to wear the catheter for a week after the sutures have been removed. It should be frequently examined and kept open and clean. Should any part be found ununited it should be touched with some stimulating application, which may probably cause it to unite, if not too large.

The importance of this preparatory treatment is also well illustrated in those cases where the parts are kept clean and in a healthy condition. Where, in chronic cystitis, an artificial vesico-vaginal fistule is made, to cure the disease, often, in spite of our efforts to keep the fistule open, it unites.

The great difficulty after an opening made by

an incising instrument is to prevent a union of the edges if the parts are kept clean.

For this reason the method of operating for bringing about artificial vesico-vaginal fistule is by the galvano-cautery. This tendency of artificial fistule to close should encourage us, in those cases that come immediately under our control after injury in labor, to resort to appropriate treatment with the hope of bringing about union by granulation. We should use a self-retaining catheter, and have the vagina washed out daily, and keep the parts perfectly free from any phosphatic deposits by applying a weak solution of nitrate of silver from day to day. If we fail to effect a permanent cure in this way, we certainly lessen the magnitude of the opening, relieve a great deal of suffering that would otherwise have to be endured, and bring about a condition that will facilitate any operation that may subsequently be undertaken for the removal of the difficulty.

COMMUNICATIONS.

PNEUMONIA.

BY HIRAM CORSON, M.D.,

Of Conshohocken, Pa.

(Continued from p. 60).

I have been in active practice continuously for fifty-two years, and during all that time have not once had occasion to believe that there was any change in the human system, or in the climate, which made it more hazardous to treat acute inflammatory affections by means of cups or leeches, and other anti-febrile remedies, than it was in the beginning of my career. I am, therefore, free to declare that it is just as safe to use them now, and they are quite as efficient, as they were in the days when the physicians of Philadelphia were using them so freely, with so much confidence and with so great success. Surgeons now perform fearful operations, by which not only is a great amount of blood lost, but the patient is also injuriously affected by the shock to the nervous system, and yet the recoveries are oftentimes astonishingly rapid. Women, in time of childbirth, often flood until they are in the very presence of death, and yet, when it is arrested, they will, in a few days, be found as bright and cheerful as if nothing had happened; soon regain their usual strength, and have no disability from their loss of blood. They bear it as well now as they did fifty years ago. Even those who would not bleed a woman in labor to save her from convulsions, have no fear that she will suffer

from a flooding which happened after the delivery of the placenta. A man may cut his leg and bleed till he faints, but no one feels that the mere loss of blood will do him any permanent injury; and yet what a hue and cry from these same people if a physician should bleed a person to remove a congestion of brain, or relieve a pain in the head or a pleurisy. I have rarely met with a graduate of the last fifteen years who has ever used a lancet, and yet these are the very persons who are so opposed to its use. They regard the older physicians who do use it as persons who are ignorant of the "valuable new remedies," (which they believe were discovered about the time they began to study medicine), when the truth is they are themselves ignorant of nearly all the means of cure, save *veratrum viride*, *aconite*, *digitalis*, a few cathartics, morphine, chloral, and—I was near forgetting them—poultices; poultices for croup; poultices for diphtheria and scarlet fever; poultices for the liver and poultices for the kidneys; poultices for the chest and poultices for the belly; and when you ask them what effect they expect from these means, they have no answer but this, "they are very much used in the hospitals now." Is there any reason why physicians who practiced forty years ago should not know as much of all the above remedies as these men educated during the crusade against blood-letting? *Digitalis* was much used long since; forty years ago I used tincture *aconite*, with good effect in many cases, as did others who then practiced; and as for newer remedies, does any one suppose that such men as Dr. John Atlee, Dr. Traill Green, Professor Gross, and hosts of others—practitioners and close students—are ignorant of the reputed merits of these champion medicines.

But I must submit some proof that blood-letting is well borne and very useful in pneumonia—as useful indeed as in times past, when it was considered of first importance.

During the Fall of 1880 ague prevailed along the Schuylkill River more than for years before. On the 26th of November I was asked, while attending another person, to see Wm. Canarra, a stout young man of 20 years, who two years before had contracted ague in Kansas, and who had returned somewhat broken in health, but for the last eighteen months had been well and strong. On seeing him, he told me that he had had a very severe chill a few hours before, that then he was laboring under a fearful headache, high fever, great thirst, and could get no rest. Without any examination of him, supposing that he had had an ague chill, I ordered some quinine,

some morphia, to relieve his restlessness and headache, and left him.

I did not see him next day (27th) till afternoon; his head was relieved, he had rested better, but was feeling badly; had some pain and soreness in the right side of the chest, had coughed somewhat, and in a basin by the bed there was a very little sputa, slightly rust-colored. Then I did what I was most reprehensible for not having done when I first saw him, namely, examine him properly. I found congestion of a great portion of the left lung and an almost entire absence of respiration. I prepared to bleed him, but he objected, on account of his *great weakness*, and here is a proper place to call attention to this characteristic of pneumonia—the *feeling of prostration*, the *sense of great weakness*, which invariably attends every grave case, and which, by the opponents of blood-letting, is deemed a clear and pressing indication for stimulants and nutritious food. I bled him about ten ounces, when he was seized with a cough and threw himself suddenly around on his side, to expectorate, twisting his arm so as to arrest almost entirely the flow of blood; then he complained of being sick, a ruse, I think, to get me to stop it entirely. I knew he was not sick from loss of blood, for the pulse gave no indication of it, but I loosed the bandage, gave him nine grains of calomel—don't be frightened—to be followed by oil, $\frac{1}{4}$ gr. morph., to allay pain, and left him for the night, without a nurse save his old grandfather.

Sunday, 28th. On visiting him I was startled by the appearance of the expectoration. The whole bottom and parts of the sides of a large white wash-basin were covered with a glairy mucus, mixed with some bright red blood and much rust-colored sputa—or, as it is sometimes called, "stewed-prunes expectoration." He had the heavy, dull flush of pneumonia, and the affection had spread over almost the entire left lung. Here was a patient before me whose disease, owing partly to my negligence, had progressed for two days without check. The little that I had done was mere trifling. I was ashamed of my work, and the question arose, in the presence of his great weakness, and of the great extent of affected lung, "have I delayed my depleting remedies too long?" Shall I now resort to them, when his lung is so heavily congested, and suffering from inflammatory engorgement? When the atmospheric air has but one lung to act upon to vivify his blood, shall I depress him still further; reduce his strength and unfit him for bearing up against the great weakness which will surely come on if the disease advance to the third stage?

I could not go out and call to my aid eminent professors who could tell me whether it was catarrhal pneumonia or croupous pneumonia, and who could assure me, warn me, indeed, that remedies which would be safe in the one disease would be fatal in the other; so I was forced to answer the questions myself. I said, two days ago this youth was well and strong, but from some cause an irritation has set up in a small part of his lung, which, like a thorn in a man's hand, has invited a flow of blood to the part. As the irritation extended, congestion followed and aided to further spread and intensify it, until now we have an inflammatory engorgement of a great part of the left lung. The primary irritation and congestion caused a chill, soon followed by increased heat, frequency of pulse, headache and great disturbance of the whole system. He has nausea, even vomiting, restlessness and a feeling of great weakness—so great, indeed, that the believers in blood poison would attribute all those symptoms, all his sufferings, to that unknown something which had insidiously made its way into his blood, perhaps months ago, and was waiting ever since for a bad cold, or some over exertion, or a sleep of a night in the cold bed of the "spare room," to help it to attack him successfully, and is now threatening his life by perverting the secretions of all his vital organs.

Although the lung is seriously affected, so greatly, indeed, that the viscous fluid and blood, some bright red and some rust colored, are being forced out of the lung by the distention of its blood vessels, they are not concerned about its condition, "for, as the disease cannot be cut short, will run its prescribed course of a certain number of days, and go through its three stages, we will," say they, "let it alone, and turn our attention to the liver and kidneys, which are draining the blood of its strength-giving ingredients." And then, to save the patient, they will send some remedy to correct the action of the kidney, something to do battle with the poison, and something else to look after the liver. Although there is great nausea and occasional vomiting, they, regardless of its condition, regardless of the aversion of the patient to every kind of food and drink, save that of cold water, which is most earnestly craved, refuse him the latter, and *force*—the word is not too strong—him to take food, in most immoderate quantities, to supply a waste which they believe is going on from kidneys and liver. Why, a learned teacher told the students, this winter, that he had really known albumen to be discovered in the urine of a patient, ill with pneumonia. What

an alarming fact! That will go into five hundred "note books." I have no belief in their theories, none in their practice.

But I have forgotten my poor patient. Poor, did I say? poor in what! Only poor in money. If I can stop the pneumonia and restore him to health, what wonderful possibilities may be his! Grant and Lincoln and Garfield were once as he is now—depending for daily bread on daily work. And now, my good boy, neither the timidity of advanced age nor the false teachings of the present days shall stay my hand, nerved to strike for your safety. There is no poison in your blood; the inflammation of your lung produces all your sufferings—your great heat and thirst, your nausea, headache, and hurried and oppressed breathing; while there is congestion, inflammation, even consolidation, there is no disorganization of your lung, and if I can arrest further extension of the inflammation by moderating the flow of blood there, and especially by relieving the blood vessels and capillaries of their fullness and distention, I shall not only arrest, but also moderate the inflammation, and then Nature will do the rest, namely, rid these small vessels of their half-stagnant blood, which press upon the small bronchioles and shut out the air. Having thus communed with myself, and remembering that I had often seen patients prostrate from excessive congestion of the lung made strong by the loss of blood taken from the arm, I bled him, as he lay there, sixteen ounces; then turned him on his side and applied two light tumblers to his back, and took four or five ounces more. Prior to these operations his pulse was 120; respirations, 42; temperature in axilla of sound side, 104°. Over the fore part of the chest I then applied cantharidal collodion freely—not cold water, or a bladder of ice and water, as I would, perhaps, have done if there had been a nurse to be always with him. As he had not been moved by the calomel, I ordered $\bar{3}$ j castor oil every three hours till the bowels should be well moved; then to have one-fourth of a grain of sulphate morphia, to be followed by a sixteenth, every three hours, if needed to suppress cough; cold water to be given whenever he asked for it, and as much of it as he could drink. Pretty sharp treatment, this, for a man who, in the hands of some of my Philadelphia friends, for whom I have the greatest respect, would have been considered so weak, from blood poisoning, that whisky, and quinine, and muriate and carbonate of ammonia, and beef tea, and other supporting things, would be needed. I saw him again at 4 P.M., seven

hours after the morning visit; respirations 40, but not labored, pulse 104, temperature 103°. He expressed himself as being much relieved. The blood drawn at the former visit was still in the bowl in which I had drawn most of it. There was a firm clot floating in the serum, with a firm, "buffy" coat covering its top. I took hold of this by a very small pinch of the ends of my fore-finger and thumb, and held it above the bowl by that alone. Did this indicate that the blood had been drawn from a person who was suffering from great weakness caused by blood-poisoning? I do not believe any man living has ever seen that firm, strong, buffy coat, come on the top of a clot of blood drawn from a man in whom there was not, at the time present an acute inflammation, or a state of robust health, or of morbid excitement of the arterial system caused by excessive stimulation. Well, this is only my opinion. Dr. Weir Mitchell, perhaps, knows more about the physical properties of poisoned blood. Until this time he had not had a regular nurse; his nights and a great part of his days were spent alone; but the nurse had arrived and I left him with her. When I saw him next day, at 10 o'clock, he had been well purged, and I found him greatly improved in his feelings, breathing only thirty times per minute and appearing very comfortable. There was, too, only a very little of the characteristic sputa in the basin. I was delighted to see how greatly he was improved, but did not visit him again that day. On the next day, the moment my eyes rested on him I knew he was worse. He had fever, said he had had a slight chill in the night, and again the basin had an increased amount of blood and rust-colored sputa, glairy and tenacious, so that the basin might have been inverted without its falling out. It was evident to me that the inflammation had been lighted up again, possibly by his rising. Dr. Pepper thinks there is danger in doing so. I bled him again, twelve ounces, when a slight nausea came over him and a warm perspiration covered his hands and arms, and I felt that I had gone far enough. I knew then that I was master of the situation. From that time I had no more trouble with him. I kept his bowels regular, suppressed his cough, when necessary, by small doses of morphia, gave milk as food—and nothing but milk—and from day to day could mark the gradual relief of the lung, the air gradually gaining access to new portions of it, from which for some days it had been almost wholly excluded.

I quote now from my notes of the case. To-day, December 5th, I find him happy and com-

fortable; a medical student in his third course of lectures, whose ears are better than mine, and who had seen him with me a few hours after I had cupped and bled him, in the very height of his difficulty, says that he can faintly hear, in almost every breath, the air in almost every part of the lung, the moist râles varying in proportion to the amount of obstruction. Mark, now, that during all this time he has had, as food, only milk—and for the first few days not a drop of even that—only water—iced-water when he could get it. In the early part of this disease—at least in grave cases—as well as in scarlet fever, diphtheria, and generally in fevers, the stomach loathes food, and I believe it is a real injury to the patient to have it forced on him. After the first four or five days this loathing of food is not present, and patients can generally take it with comfort and advantage. As soon as I have subdued the inflammation I allow nature to do the rest of the work. I care but little for the kidneys or the liver, knowing full well that, now, when the local irritation has subsided, and the heart is resuming its ordinary regular work, they too will return to their accustomed duties, from which they had been drawn by their sympathy with their neighbor, the lung, in his great distress.

The above was a badly managed case in the beginning, and I am not proud of it. If I had done my duty on the first and second days, he would have been quite well in a week. However, he is as well and hearty now as any one, and the case serves well to show that bleeding may be freely practiced in quite an advanced second stage of active inflammatory engorgement, with safety and good advantage. If agreeable to you and your readers, I shall be gratified to have an opportunity to give a few more cases to show the value of blood-letting.

HOSPITAL REPORTS.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

A CLINICAL LECTURE BY WM. PEPPER, M.D.,
Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WILLIAM H. MORRISON, M.D.

Catarrhal Phthisis, Tuberculosis of the Lungs, Tubercular Ulceration of the Intestines.

GENTLEMEN:—I bring before you to-day the specimens from a case, the history of which is of a very interesting character; so much so that I shall beg your careful attention to the history and symptoms before turning to examine the specimens.

The patient was a young man, about twenty-three years old, the eldest of a family of twelve, living in a healthy district of country. At the age of fourteen he took charge of a responsible position, and wore himself down. He was never very vigorous, and about the early part of last year he was on a midnight sleighing party and took a heavy cold, which undoubtedly resulted in a pneumonia. He was very sick for a few days. Then he got about again and continued to have cough, but not much expectoration; some failure of flesh and strength; but he still went on with his business.

When I say he had a pneumonia, I do not mean that he had a severe attack of croupous pneumonia, but probably a slight attack, a catarrhal pneumonia. The cough became less and less marked; but he then began to be troubled with diarrhoea, which continued more or less until the close of his life. Again, he paid very little attention to the diarrhoea, ate about what he pleased, and kept about his business. He took a good deal of patent medicine, and went to a number of places, but with little relief.

I saw him first on the 1st day of May, seventeen days ago. He reached this city with great difficulty; the journey was almost too much for him. I learned that it was thought that he had not had much fever, no cough nor expectoration; that his lungs were regarded as sound, and if he could go to the seashore, take plenty of oysters, and so on, he would come around all right.

His appearance was horrible; he was emaciated to the last extremity. When I saw him his pulse was rather slow, and the temperature about 98° ; this was in the morning, about noon. When I saw him next day and made a careful examination, I found that it was one of those unusual cases of very extensive disease with very few general symptoms. Physical exploration is, in such cases, the only means of determining the condition present, but in some such cases, because of the debility of the patient, and the fact that, owing to the flux from the intestinal canal, the amount of secretion from the lung is small, there is often little cough and expectoration, and the physical signs are obscure and only developed with difficulty.

The physical examination showed that there was no extensive dullness at any part, and the respiratory movement was everywhere impaired. The chest was long, shallow, poorly developed, of the phthisical form. At some places, however, after making the patient cough—and in such cases, where the movement of the chest is impaired and the respiratory murmur feeble, you will, if you make the patient cough, develop sounds that you could not hear before—I heard unmistakably, soft râles, such râles as indicate softening of an exudation in the alveoli of the lung. It was clear that there were scattered seats of disease in the lung; at no place had they run together, forming large masses, and at no place did they form a cavity.

I think that in these cases the lung tissue around the diseased part becomes emphysematous, and thus tends to cover up the dullness. Now these obscure physical signs are met with in certain cases of chronic catarrhal phthisis, where

there is not much expectoration, and particularly where there is associated intestinal disease, because in this the amount of fluid in the air passages, which you know gives rise to many of the physical signs, is much diminished.

Secondly, I learned that the stools varied in number from one to a dozen in the twenty-four hours; in color from yellow to greenish or blackish, sometimes containing specks of blood and sometimes little patches of mucus; that there was a good many cutting pains through the belly, that these alternations of diarrhoea, from worse to better and from better to worse, seemed to be produced by changes of weather and indiscretion in diet.

There was no thickening, that I could find, of the intestinal walls, at any point. The abdomen was a little distended and a little boggy on pressure, but the great emaciation everywhere else made the prominence of the abdomen more marked. I formed the opinion that there was extensive ulceration of the bowels, secondary to the lung disease. That it was probably associated with enlargement of the mesenteric glands, and quite possibly with subacute peritonitis.

I was surprised to learn the next day that there had been an extraordinary change of temperature. The variation of temperature in this case the day after he came in, was from 97° or 96° in the morning, to 102.5° at night. Six days after this came another and most extraordinary range of temperature, from 96° in the morning, to 104.5° at night, followed by a fall the next morning to 96.8° . This temperature movement is more remarkable because, as you see, its great range is caused by going below normal, showing a marked condition of mal-assimilation and poor calorific power, causing the cold stage to be attended with a very marked reduction of temperature, so that the intense fever only carried the temperature up to 102° , 103° and only in one instance to 104° ; the daily range being from 6.5° to 8.5° .

When I found this young man with his skin cool, his pulse seventy-eight per minute, and his mind clear, it gave me a favorable opinion of his case. But when I noted this terrific hectic fever, I recognized that here there must be a most enormous amount of inflammatory disease, of an irritative or destructive type, to keep up such a state.

The course of the case was rapidly downward. The diarrhoea was controlled by the use of a very carefully restricted diet, the avoidance of all remedies by the mouth and the use of injections of nitrate of silver and opium; so that soon he passed but one stool a day. Under this treatment his tongue, which had been aphinous and raw, cleared off somewhat, his stomach became a little easier, and with this improvement you will observe that the range of temperature became a little less extreme, but none the less did the downward course continue. He soon became delirious and died last night.

Let us first examine the lungs. The right lung is more extensively diseased than I had imagined. I knew that it was riddled, but I did not expect to find such marked changes. There are no large cavities, but here are two or three small ones, about half an inch in diameter. The upper lobe of the right lung is riddled with gray

tubercles. Unquestionably a true tuberculous formation has taken place secondary to the old pneumonic process, and traces of the pneumonic process are found in the upper part of the lung, where softening has occurred, and this tubercular infiltration is all through the upper lobe. The lower lobe is congested and cedematous, but presents few, indeed, I think, scarcely any points of disease.

Upon the left side I find the upper lobe very extensively involved, and in just the same way as on the right side, except that here the lesions are more recent. They consist of infiltration with grayish and yellowish-gray miliary bodies, not sufficient, indeed, to cause complete solidification, but little blocks of solidification are found; between which are areas of crepitant tissue. There are a few cavities. The lower lobe presents a few scattered nodules of disease.

We have, then, extensive lesions in both upper lobes, originating in a pneumonia, and now the development of true miliary tubercles, while the lower lobes remain comparatively healthy. Think how remarkable it is that this man was said to have no organic disease, but at the same time remember the peculiar circumstances; for the man's power of filling his lungs was so weak that nothing was audible over his lungs, and it was only when I made him cough, thus causing him to take a deep inspiration, that I could develop any râles.

I shall now take up the other organs as I have them.

The kidneys are normal. The urine was normal.

The spleen is very much enlarged. About twice its natural size. Its structure appears to be normal.

The liver is normal in size, color and weight. I always speak with diffidence in regard to the presence of tubercles in these organs, because minute miliary tubercles may exist and only be discovered by the microscope.

I turn now to study the intestinal canal. The stomach presented no evidence of disease, and it is not necessary to open it. I see at once enormous enlargement of the mesenteric glands. I am now at the termination of the ilium, in the ileo-cæcal valve. This enlargement is probably most marked in the middle of the ilium, but it extends far up towards the duodenum. Now I shall ask you to note further the characteristics of this enlargement. We see, in the first place, that the glands are of a grayish-yellow color, not pink or red. I dwell upon this because I want to call attention to the difference between this enlargement and that which takes place in typhoid fever, when we consider the condition of the intestinal mucous membrane in relation to that of typhoid fever.

The enlargements vary in size from a small pea to a large almond. On section they present a pink and a yellowish periphery. In typhoid fever the gland is softer and throughout reddish or pinkish. This ulceration is different, because the gland has evidently undergone cheesy degeneration. Fatty change has shown itself here, just as it has in the lungs.

Although it is true that the mesenteric glands are enlarged, they are not more enlarged at the

ileo-cæcal valve than they are higher up, in fact, they are scarcely as large as they are higher up. In typhoid fever, as you know, it is the glands about the ileo-cæcal valve that are by far the most enlarged, and as we go along the ilium, we find the enlargement grows less as we pass upward. Chronic enlargement of the mesenteric glands is often found in old cases of ulcer of the bowel. My judgment is that there are plenty of true tubercles in these glands. Their enlargement is common in all forms of ulceration of the bowel, particularly when the ulceration is of a tubercular character. It would seem that these glands had undergone irritative hyperplasia, and that in various places had been formed tuberculous nodules.

Now, as I expected, I find tubercular peritonitis also present. The peritoneum is purplish and congested, and scattered over it are scores of miliary tubercles. This is most marked towards the cæcum. I find also numerous yellowish granulations.

Lastly, let us see the condition of the mucous membrane. In opening the bowel, whether the ulceration be typhoid or not, it should be opened at the insertion of the mesentery, not opposite to it, because it is important that we should be able to observe the relation of the ulcer to the glands of Peyer, and these lie at the convexity of the arch. I shall only open a couple of feet of the intestine, extending the incision for a short distance into the cæcum. The only basis of sound practice of medicine and of sound diagnosis is morbid anatomy. I always take every opportunity that presents itself, to impress on your minds not only the appearances, but to associate them with the symptoms.

I have now opened and washed the bowels, and you see, there is scarcely a particle of mucous membrane left. Serpiginous ulcers, which defy localization, extend everywhere. This is not at all the appearance of ulceration of Peyer's patches. The latter are oval in shape, seated in the middle of the bowel when it is opened as I have directed, with their long axis corresponding to the long axis of the intestine, surrounded by a raised lip, and between them perfectly healthy mucous membrane, with enlarged solitary glands, which may or may not be ulcerated. I find here about an inch of mucous membrane in which there is an oval ulcer, but its long axis is transverse. If it were a typhoid ulcer its axis would be longitudinal. When we come to the ileo-cæcal valve, there is no mucous membrane for several inches. The condition is just as bad in the large bowel as in the small. There are the lesions of chronic dysentery, chronic ulcerative enterocolitis. These are just the kind of lesions that are met with in old cases of chronic dysentery. Are there any miliary tubercles in the intestine? That can only be told by a microscopical examination, but I think there are.

We have, then, in this case, the most advanced and intense lesions of tuberculosis of the lungs and of the intestinal canal, originating in a pneumonia of one or both lungs, unnoticed and improperly treated, not cured, grafted on a system exhausted by premature and excessively hard work, but with no tuberculous tendency.

This is an acquired condition, for he was one of a family of twelve children; the grandparents and the rest of the family were vigorous and well, living in a perfectly healthy district. The inflammation went on to cheesy degeneration, infection of the system and the development of tubercles in both lungs and the intestinal mucous membrane, and lastly, secondary deposits in the peritoneum, and secondary involvement of the mesenteric glands.

Galloping Consumption.

Here is a patient suffering from this same process of infective tuberculosis. He has been barely able to get here to-day.

John Gallagher, not quite seventeen years old, a delicate lad. He has been engaged in measuring grain from 5.30 A.M. until 9 or 10 P.M. One sister died at the age of fifteen years and six months, and another at the age of eighteen years. Both of phthisis. The first died after nine months' sickness, the second after six months. His mother died of cancer of the axilla. His father and one brother are living.

With this hereditary tendency, he is put to work in a close, dusty atmosphere, working sixteen or seventeen hours out of the twenty-four, for the last four years. It is hardly necessary to say what the inevitable result has been. He took cold, that is, his system became so exhausted, his nutrition so impaired, that finally some change in the weather, or something of that kind was sufficient to set on foot the inflammatory process. The expectoration became profuse, the night-sweats have been continuous. Dyspnoea has been a marked symptom from the first. His features are drawn and pointed, eyes sunken and hollow, the respiration exceedingly rapid, the surface bathed with sweat and the pulse very rapid, 160 per minute. This, probably, indicates the height of a paroxysm of hectic fever, which often has its maximum about two or three o'clock. His temperature is 102.5°.

On auscultation I hear innumerable fine crepitant râles on inspiration and expiration, at the left apex, some at the mammary region, less numerous but distinct at the sub-axillary space, less marked but quite distinct posteriorly.

Observe, that with this complete infarction of the whole lung with miliary tubercle, for there is not one-eighth of a cubic inch that has not got plenty of them, there will be, I think, as there is generally, so much dilatation of the vesicular structure as to prevent any considerable degree of dullness. This is not vesicular resonance, but vesiculo-tympanic. On the right side I find a large cavity. Here has been, I suppose, the origin of the disease, a pneumonic inflammation of the right upper lobe. Here we have cavernous respiration, with gurgling râles, as though one was blowing soap bubbles. The blowing breathing is distinctly heard over the scapular region, showing that the cavity is deep and surrounded by solidified lung tissue.

Percussion at the right apex gives a tympanic note, and an extremely marked cracked-pot sound. We have here a large cavity with thin walls anteriorly. Below the solidification is great enough to give considerable dullness.

The bowels are open sometimes two or three

times a day. They contain no blood, but are thin. There is no pain in the belly. He never spat up blood until last Sunday. The tongue is pale, coated and tremulous, as he is all over. (The patient being sent from the room, Dr. Pepper continued.)

Here is a horrible illustration of the rapid progress of true tubercular disease, being, as it so often is, induced by some previous malnutrition or exposure of a system inclined by hereditary tendencies to cachectic disease. It is no wonder, then, that this lad, exposed at an immature age to excessive over exertion, in an atmosphere filled with irritating particles of dust, should become so rapidly run down with disease. I have no doubt but that he also has ulceration of the bowels, and if the disease was not making such rapid progress, we would have the lesions which we saw in the other case; but he will probably be dead in the course of two weeks. This is a case of galloping consumption, so called.

MEDICAL SOCIETIES.

NEW YORK STATE MEDICAL SOCIETY. ANNUAL MEETING.

The Society met at Albany, February 1st, about one hundred and twenty-five members being present, in spite of the excessive severity of the weather. During the session a daily report of the proceedings was published by the Medical Society of the County of Albany, in the form of a daily edition of the *Medical Annals*. We are indebted to this for most of the report which we furnish.

The President, Dr. Wm. H. Bailey, of Albany, called the Society to order at 11 o'clock A.M., and read the opening address, chiefly devoted to the consideration of the social and legal relations of the profession and to the necrology of the Society.

Passing over the business matters which occupied the session, the following scientific papers were among those read:—

Dr. David Webster, of New York, read a paper on

SYMPATHETIC NEURO-RETINITIS.

After a careful consideration of seven cases of this affection mentioned by Von Graefe, Stettburg, Schweigger, Alt and Pooley, and two cases reported by himself, Dr. Webster is of the opinion that the question of the sympathetic character of this disease still remains an open one.

Dr. Norman L. Snow, of Albany, read a paper on

LITHOTRIPSY, WITH ENTIRE REMOVAL OF FRAGMENTS AT SAME SITTING. BY BIGELOW'S ASPIRATOR.

After an interesting review of the history of the operation, the Doctor reported the following case:—

Robert A., an American by birth; age fifty-three; family history good; first noticed trouble in micturition in spring of 1879. In November of same year chronic cystitis was diagnosed, and treatment therefor instituted during the fol-

lowing winter. In October, 1880, was examined with Thompson's short curved sound, and a small stone detected, which rapidly increased in size until December, when the operation was performed. The entire time occupied in the operation was thirty minutes; weight of fragments eighty grains. On January 6th, ten days after the operation, he was able to attend to business.

Dr. Charles A. Bull, of New York, then read a paper on the

PATHOLOGY OF ORBITAL TUMORS, INVOLVING THE BONES OF THE ORBIT.

He attributes the recurrence of these growths to the cellular elements left in the shreds of orbital tissue, or in the many fissures and sinuses communicating with the cavity of the orbit, or that the periosteum or bone may have been the primary seat of the disease. He classifies these tumors as pure sarcoma, myosarcoma, or fibro-sarcoma. The secondary processes observed in bone and periosteum are a general infiltration, softening and degeneration of bone tissue, and the development of exostoses, osteophytes, from and in the walls of the orbit. The influence of locality upon the development of sarcomata is clearly evident. The osteo sarcomata appearing on the surface of bones and the softer forms in the medullary cavities. But in the orbit, the tumors are mostly of the medullary variety. In removing primary intra-orbital sarcoma, careful search should be made through the entire orbit for enlarged lymphatics or infiltrated glands. Three cases were reported, of operations for the removal of intra-orbital growths. From a study of these cases, Dr. Bull thinks that operative interference hastens the recurrence of the tumor, and that the stripping up and removal of periosteum hastens the return in the bone, even when the latter has been scraped at the time.

Dr. L. Duncan Bulkley, of New York city, then read a paper entitled

FAVUS AND ITS TREATMENT BY A NEW METHOD OF DEPILATION.

After detailing his experience with several methods which had proved unsatisfactory, he advised the preparation of sticks of various sizes, from one-quarter to three-quarters of an inch in diameter, and cut off in lengths of two or three inches.

The formula is as follows:—

R.	Cerae flavae,	3 ij	
	Lacæ in tabulis,	3 iv	
	Resinae,	3 vj	
	Picis Burgundicae,	3 x	
	Gummi dammar,	3 iss.	M.

By the use of these differently-sized sticks, they can be applied to affected surfaces of various sizes.

They melt at a comparatively low temperature, and yet are hard at that of the body. The hair should be cropped short over the part to be treated, and as the stick is applied, a slight rotary or twisting motion is given to it. After it has been applied for several minutes, it is removed by bending it over, and drawing the hairs in suc-

cession. The hairs thus left in the stick are burned off. The operation may have to be repeated.

Dr. A. Mathewson, of Brooklyn, reported a case of

TRANSPLANTATION IN A CASE OF COMPLETE EVERSION OF LEFT UPPER LID,

as the result of contraction from burns. The lid was freed by dissection, and transplantation performed of a piece of skin three inches by one and a half inches, without pedicle. The result was union throughout by first intention. The advantages of the operation were said to be the ease of execution, with greater surety of success than by the old methods with pedicle or sliding flaps.

Dr. Daniel Lewis, of N. Y. city, then read a paper on

DRESSING OF THE UMBILICAL CORD.

He advises that the cord should be cut *before* the ligature is applied, and thoroughly emptied of blood and serous contents, thereby reducing the amount of material to be sloughed off to the minimum. It is then tied and twisted sharply three or four times, which torsion so closes the umbilical vessels that hemorrhage is about impossible, in case the ligature should prove imperfect. A band of rubber adhesive plaster, two by eight inches, is then tightly applied over it and allowed to remain until the parts are thoroughly cicatrized. This device is believed to be sufficient to prevent any protruding navel or umbilical hernia.

Dr. L. E. Felton, of St. Lawrence, read a paper entitled

MEDICAL INDUCTION COILS.

The Doctor said: A cell is used of original and peculiar construction, and an interrupter, which will produce most rapid vibrations. The current is regulated by means of a sheet of copper, bent over the coil, the connection being completed by means of a movable bar, which will bring any desired length in contact.

When the edges are in contact, the current is induced in the cover, as offering less resistance than the patient; but as the bar is removed, and resistance increased, the current which flows through the patient is correspondingly increased.

Second Day—February 2d.

Among the papers read on this day may be specified:—

Dr. J. S. Warren, of New York city, read an abstract of a paper entitled

HYSTERO-NEUROSIS OF PREGNANCY.

From a consideration of several hundred cases, he does not believe that there is any specific for this affection, but that each case requires its own special treatment. Vomiting is not always, nor even in most cases, sympathetic, but arises from nervous influences, or from changes in the thyroid, spleen, liver and kidneys.

Dr. H. G. Piffard, read a paper on

MEDICINAL ERUPTIONS.

He stated that until within a very few years hardly any drug, except arsenic and the diaphoretics, was credited with a direct action on the skin. Effects upon the healthy skin, following the ingestion of drugs, are rare, yet—on this

very account—important to be recorded for reference. Practitioners should know all the irregular and abnormal effects of remedial agents, lest a medicinal rash be mistaken for an idiopathic affection of the skin, and the unsuspected cause be permitted to remain in operation. Thus far, dermatology has mainly considered the symptomatology and pathology of cutaneous affections, springing from what might be termed natural, though frequently obscure causes. There is need of careful observation of a different class of cases: those which arise through the agency of means intended to combat disease, but which, in turn, may become the originators of morbid action. While in many cases these effects are unusual, and commonly explained as due to some idiosyncrasy, it is none the less important that they should be recognized at the time of their occurrence, and their true cause.

Dr. George F. Shrady, of New York city, related a rare case of

CONGENITAL INTRA-PARIETAL HERNIA.

In which he was able to make a diagnosis before death. The patient was fifty-four years of age; suffered from strangulation; refused an operation, and died on the eleventh day. A drawing of the specimen was presented, showing a congenital inguino-scrotal hernia, connected with which was a diverticulum of peritoneum, forming a supplementary hernial sac, extending upward and outward between the external and internal oblique muscles as far as the anterior superior spine of the ilium.

Dr. E. V. Stoddard, chairman of

COMMITTEE ON HYGIENE,

reported the general summary of the work for the year. The subject for observation had been that of diphtheria. Careful investigations had been instituted as to its contagious character, with especial view to the relative influence of personal contact, infection by clothing, and unsanitary surroundings. Its contagious character being undoubted, the question of *quarantine* in the

public schools, as well as the family, was urged by the committee, and will serve as the subject for the coming year.

Dr. Elisha Harris, one of the State Commissioners of Health and Secretary of the State board, called attention to the present widespread prevalence of diphtheria and the utility of the general observations and records of the medical profession relating to its causation and prevention. He urged the necessity of bringing under the best possible control the unguarded causes of the distribution of diphtheria. He explained the necessity of isolation of all who are convalescing. The State Board of Health find it a duty to investigate the causes and modes of distribution—its infective as well as local causes. He called attention to the necessity of physicians teaching and inducing the proper care in preventing the spread of this disease.

Dr. E. C. Seguin, of New York city, read a paper on

THE EARLY DIAGNOSIS OF SOME ORGANIC DISEASES OF THE NERVOUS SYSTEM.

In diagnosing posterior spinal sclerosis, the following symptoms were stated as characteristic of the first or pre-ataxic stage: the peculiar pains, the diminution of various reflexes and the paralyzes of ocular muscles. The earliest characteristic symptoms of paralytic dementia are tremors or fibrillary contractions, especially in the tongue, facial and manual muscles; a tremulous, thick and vibratory speech; irregularity of the pupils, and dementia. Tumors located in the motor zone are *sometimes* capable of early recognition. Their symptoms are localized convulsions in peripheral muscles; equally localized paralysis of peripheral parts; neuro-retinitis or choked disk, and localized headache.

THE PRESIDENT'S ADDRESS.

The annual address was delivered by President Bailey, at the Assembly Chamber of the New Capitol, on the duties and opportunities of the medical profession.

(To be Continued.)

EDITORIAL DEPARTMENT.

PERISCOPE.

Treatment of Abscess of the Liver.

The *Medical Press and Circular* states that at the Academie de Médecine, in November, a discussion took place on the communication made by M. Rochard relative to the treatment of abscess of the liver by a large and direct incision, combined with the antiseptic method of Lister. M. Depaul commenced by relating a case which occurred on board a steamer when he was going out to Brazil, six years ago. A passenger was suffering from a liver affection for some time, and had come to France to consult different physicians and surgeons of more or less note, and who had expressed different opinions on the

nature of his case and the treatment to be adopted. He was now returning home, little benefited by his voyage. Being called in consultation by the ship surgeon, M. Depaul, after a minute and careful examination, discovered fluctuation in the organ in question. Soon it became evident, by the increase of the tumor and the commencing redness of the skin, that the pus was making its way to the exterior. M. Depaul proposed to make a large incision down on the abscess, which was accepted, after some hesitation. Accordingly, he made an incision of an inch and three-quarters in length, which divided successively the skin and the subjacent tissues, exposing a thin layer, under which the pus could be distinctly seen. He made a simple puncture in the layer, which gave exit to more than half a pint of

fetid pus, mingled with hepatic debris and some bile. After the evacuation of the matter destructive injections were employed, and before the ship arrived at her destination the patient was in a fair way of recovery. M. Depaul terminated by reminding the meeting that the Lister dressing was not employed in this case. M. Rochard, advocate of the new method, replied that he had known twenty cases treated according to the old rules, and the twenty died; whereas, three in which the Lister treatment was employed recovered. Surgeons who used this latter method need not trouble themselves as to whether the peritoneum be adherent to the abdominal walls or not, and take no care to provoke it either.

How to Prevent Perineal Laceration.

Mr. Alex. Duke writes to the *Medical Press and Circular*, Nov. 24: The best preventive treatment of laceration which I have found (and which I dare not claim as original, as I presume it has been tried before, but which I see no mention of in the text-books of midwifery) is this: When I find the head fairly engaged in the pelvis, and advancing with each pain, I take my seat by the patient's bed, and having lubricated my left thumb or the two first fingers of my right hand, I introduce either into the vagina, and at the onset of a pain draw back the perineum firmly but gently toward the coccyx, relaxing the tension gradually as the pain lessens, till the next ensues, and so on till I can draw back the perineum with very slight effort. I thus tire out the muscular structures and produce sufficient relaxation for the head to pass. In most cases so treated the perineum is in no danger, but when the pubic arch is narrow, I take the additional precaution to foment the parts, and use an inunction of lard, and also allow the head while passing through the vulva to glide over my lubricating fingers, using them as a shoe-horn, so to speak, while I direct the head forward by pressure with my left hand below the coccyx or a finger in the rectum.

It has always seemed anomalous to me that the perineum should be expected to dilate on such a short notice, namely, the "process of extension," while (dilatation of) the os and cervix occupy such a considerable time, even with the additional help of Nature's hydrostatic dilator, viz., the bag of waters.

The drawing back of the perineum produces no additional pain, as it is done during a uterine contraction, and I feel sure if nurses were educated as to the proper way of dilating the perineum previous to its distention with the foetal head, we should see less and hear less of lacerated perineum.

Physiological and Therapeutic Action of Benzoic Acid.

The *Lancet* states, that from his experiments Schulte has found that the introduction of benzoic acid into the stomach of warm and cold-blooded animals always causes irritation of the mucous membrane, extravasation, and hemorrhagic erosion, and that similar irritation is sometimes observed, even when benzoic acid or its salts have been introduced by injection under the

skin, or into a vein. In the latter case the pulse and respiration are at first accelerated, and afterwards retarded. The blood-pressure is not influenced by slight injections, but is lowered by stronger ones, and the phenomena are independent of the vagus nerve. Whenever the dose amounts to more than two-thousandths of the body weight of the animal, toxic symptoms occur, followed by death. Salkowski has pointed out that when benzoic acid is given the urine commonly contains a substance which is capable of reducing sugar. This body is not soluble in ether, but it is soluble in alcoholized ether and acetic ether. It is very slightly soluble in water, and thus is distinguished from both benzoic acid and hippuric acid. The salt it forms with barium is insoluble in water, and contains both nitrogen and chlorine. Schulte has found that the appearance of this substance in the urine corresponds in time with the appearance of toxic symptoms. In the therapeutic use of benzoic acid and benzoate of soda for diphtheria, acute and subacute articular rheumatism, erysipelas, typhus, diabetes, nephritis, interstitial phthisis, peritonitis, etc., the reducing substance was never found in the urine after a small subcutaneous injection, but was found when a larger injection was given. The salt was found distinctly useful only in acute articular rheumatism and diphtheria.

Two Cases of Spinal Irritation.

The subjoined interesting cases are given in the *Glasgow Medical Journal*, January:—

CASE 1.—The patient is a strong, robust-looking young woman, aged 25, and evidently hysterical. She was admitted to the hospital on the 15th of November. She made no mention of any affection of the spine, but complained of pain underneath both mammae, and in the left iliac region. The pain under the left mamma had been present for about eighteen months, and was of a dull, aching nature; that on the right side was much more acute, and commenced suddenly in August last.

The thoracic and abdominal viscera seemed quite healthy, but on making firm pressure with the fingers along the spines of the vertebral column, two tender spots were discovered at different levels, corresponding very much to the points at which the spinal nerves issue, which supply the areas in which pain was complained of. The patient winced visibly when those points were pressed.

A tonic mixture containing strychnia and quinine was ordered, and on the 18th of November two large blisters were applied over the tender parts of the spine. This was followed by a certain degree of relief from the mammary and iliac pain, by no means, however, complete. On the 29th, therefore, the blisters were repeated, and on the 8th of December the patient left, quite relieved of her symptoms.

CASE 2.—The patient is aged 22, and enjoys fairly good health, but for three months before admission to hospital, on the 27th of November, she suffered from pain about three inches below the left nipple; this was increased during inspiration; she had also a dry spasmodic cough without any expectoration, and exercise of any kind

rendered her breathless. After taking food, too, she complained of pain in the gastric region, and was troubled with sour eructations. Her appetite was good. Two years ago the menses were suppressed for three months, and during that time she had an attack of pain in her breast, as at present, but on the return of the menses the pain disappeared. There was no apparent disease of the stomach at the date of admission to the hospital, and the heart and lungs seemed also sound. On examining the spine, however, tenderness was detected from the sixth dorsal to the first lumbar vertebra, and chiefly on the left side of the spine. Of this condition the patient was quite unaware until examined. On the 10th of December she was wet-cupped over the upper portion of the tender part of the back, to 10 drs. The almost immediate result of this was the entire disappearance of the spasmodic cough and the stomach symptoms, but the mammary pain still continued. On the 16th of December the cupping was repeated over the lower portion of the tender part, with the result of removing the pain of the side.

Indigestion from Disordered Liver.

Dr. T. Lauder Brunton says, in the course of an article in the *British Medical Journal*, January 8th, 1881:—

"One cause of indigestion is disordered relation between the stomach and the liver. Usually, the bile does not enter the stomach, but remains in the duodenum and intestines, but when indigestible and irritating substances enter the stomach, the bile may flow into it, producing very unpleasant symptoms; not merely does it interfere with digestion, by precipitating pepsine, but the local irritation which it produces in the stomach itself, as well as its general effect upon the nerve centres after being absorbed into the blood, causes the patient to suffer from dullness and headache. In Dr. Beaumont's interesting experiments upon Alexis St. Martin, he notes, that where he introduced several muslin bags, containing various articles of diet, into the stomach, St. Martin, shortly after their introduction, began to complain of a sense of weight and distress at the scrobiculus cordis, slight vertigo, and dimness of vision. This continued to increase, and became quite severe, accompanied, at the latter part of the time, by slight pain in the forehead and through the eyes, and a sense of tightness or stiffness across the breast. His countenance had changed from a florid and healthy, to a sallow, sickly appearance during the experiment, and a soreness at the pit of the stomach continued, after the extraction of the bags, for eight or ten hours, and had not entirely subsided next morning. Morbid action of the inner (?) membranes was evident next day, with considerable erythema and aphthous appearance. Some of the bags were covered with a thick, mucous coat, tinged with yellow bile; and to the entrance of the bile into the stomach Dr. Beaumont ascribes the symptoms observed in St. Martin, as he had noticed them also in similar experiments. Here, it was apparently the irritation of the indigestible muslin bags which caused this bilious attack in St. Martin; but

other indigestible substances will produce the like effect.

Nor is this the only disturbance in the relation between the liver and the alimentary canal which is of importance in the production of indigestion. I have mentioned the probable effect of vaso-motor alterations in the liver upon the vascularity of the stomach and intestines, and upon the solution and digestion of food within them. But there remains still another condition of great importance. The digestion of food is not entirely accomplished in the alimentary canal. In addition to what used to be called the primary digestion in the stomach and intestines, there is the secondary digestion, which appears to be of no less importance. Farinaceous foods are converted, in the intestinal canal, into grape sugar, but apparently only a small amount of this sugar reaches the general circulation unchanged. It first undergoes conversion into glycogen in the liver, and is thence passed out, as it is wanted, into the general circulation. The albuminous constituents of the food are converted, in the alimentary canal, into soluble peptones, but, like the sugar, these also do not reach the general circulation unchanged. Excess of sugar in the systemic circulation is injurious, as we see in cases of diabetes, but excess of peptones appears to be still more injurious. The action of these bodies has been recently investigated by Professor Albertoni, of Genoa, and by Professor Ludwig and Dr. Schmidt-Mühlheim in Leipsic. Albertoni has found that peptones, when injected in the circulation, deprive the blood of its power of coagulation, at least in dogs and cats, and probably in all carnivorous animals. It has not the same power in sheep or rabbits, and probably has not the same action in herbivora as in carnivora. Ludwig and Schmidt-Mühlheim also observed the effect of peptones on the coagulability of the blood, and they have investigated their action upon the blood pressure. They found that when the peptones are injected into the veins the blood-pressure sinks considerably; and, if the quantity introduced be great, a soporose condition, convulsions, and death are produced. It is, therefore, evident that, unless there were some provision for the alteration of peptones before they enter the general circulation, we should be poisoned by the products of our own digestion. Ludwig and Schmidt-Mühlheim were unable to settle precisely where the peptones underwent transformation, most of them having apparently already disappeared from the portal blood before it reached the liver. Two other observers, Plosz and Gürgyal, were led by their experiments to fix upon the liver as the place where peptones undergo transformation, and it seems not improbable that, to some extent, they are right. The liver, like the stomach, may be overworked, and both organs are liable to great functional disturbance from violent or depressing emotions.

On the Means for Dilating the Uterus.

Dr. Leopold Landau (Volkman's *Sammlung Klinischer Vorträge*, N. 187,) mentions, first, the use of various metrotomes constructed after the model of the lithotome caché, but of these he disapproves, on account of the dangers of their

cutting too much, of bleeding, and of subsequent stenosis. For similar reasons he objects to the use of such instruments as Sim's or Emmet's knives or scissors. To dilate the os internum by means of such blunt instruments as those of Sims, Ellinger, Tiemann, etc., requires, he maintains, that the patient be narcotized and considerable force used, while there are similar objections to their use as to that of cutting instruments. Sponge-tents favour infection, so that septicæmia following their use is not rare. It is impossible, also, to render them thoroughly antiseptic without unfitting them for their purpose. The use of an india-rubber covering to the tent, with a stream of water thrown into it, is cumbersome, and also does away with the advantage to be got from the removal of fluids from the surrounding tissues by the sponge. Tangle tents are not so liable to lead to infection as are the sponge tents, though occasionally, from decomposition of their gelatinous structure, they may cause it. They are, the author says, very uncertain and unequal in their action, and have not a very great dilating power, being sometimes retained constricted by the internal os, while above and below they may be dilated. Dr. Landau then goes on to recommend the use of tents made from the South American swamp plant, *Nyssa aquatica*, by Tiemann, of New York, and called tupelo-tents. These can be made of any size, and have a much greater dilating power than tangle-tents, while they require less than half the time. They exercise, too, the same dynamic effect on the uterus as do sponge-tents. They swell to a much greater size than tangle-tents, and are not attended by the risks of infection. After recommending strongly their use, the author proceeds to discuss at length the question of when dilatation of the cervix is indicated, and strongly disapproves of the forcible method of Fritsch, as also the incision method recommended by Schroeder.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—The *Archives of Dermatology* begin the year in enlarged form and on superior paper. The contents are always of the best, and all specialists in that department—including syphilis—should subscribe to it (\$4.00 per year. G. P. Putnam's Sons, New York).

—The January number of the HALF-YEARLY COMPENDIUM OF MEDICAL SCIENCE will be found a synopsis of all branches of medicine, American and Foreign. A full table of contents will be forwarded to any one on application: Inasmuch as no article in the COMPENDIUM appears in the MEDICAL AND SURGICAL REPORTER, the two journals are eminently adapted to be taken together, and combine an unequaled amount of original and carefully selected reading matter. Pub-

lished at the office of the MEDICAL AND SURGICAL REPORTER.

—One of the recently published anatomical aids is the "Pictorial Manikin, or Movable Atlas of the Human Body," showing the position of the Internal Organs, by means of superposed colored plates." By Prof. G. J. Witkowski, M.D., of Paris, with an English translation of the text, by Robert Hunter Temple, M.A., of London, and an Introductory Essay and explanatory Anatomical Index, by Prof. D. A. Loomis, M.D., of New York. (Published by Joseph Cristadoro, 93 William street, New York. Price \$5.00). We have long been familiar with this method of teaching anatomy, and, indeed, this is not its first introduction to the American public, as some years ago Dr. G. H. Napheys prepared and had published a similar "movable atlas," or some plates of one. We believe, however, that it did not turn out to be a popular mode of study. The present one is larger, and the text sufficiently full for popular instruction, for which, apparently, it is chiefly designed. Indeed, for the general reader or for schools this series merits strong praise. But if any medical student tries to make it take the place of steady, plodding, laborious dissecting, he will commit a grave error.

BOOK NOTICES.

Transactions of the Medical Society of the State of Pennsylvania. Vol. XIII. Part I. 1880.

This part makes in all a volume of nearly 500 pages. One half of this is filled with the regular minutes, reports and addresses; the remainder with county reports and rosters. As we gave at the time of the meeting a sufficiently full account of the former, we may now devote most of our attention to the county reports, which are not read before the Society, but are forwarded to the Publication Committee.

These reports are an excellent feature, and we know of no other State society which gives them so much attention as that of Pennsylvania. A printed form is furnished for them, but this is not, and need not be, generally adhered to. It is rather intended as a series of hints to guide local researches. We regret, however, to see this distinctive and admirable feature showing signs of atrophy. Omitting the Obituary notices, and the Philadelphia Society, the reports from the State at large hardly make up a hundred pages. In these are several articles which well merit the reader's attention; we refer to several cases of renal disease, by Dr. G. W. Smith (p.

251); the etiological relations of phimosi and præputial adhesions to epilepsy by Dr. D. F. Unger (p. 296); a case of empyema, by Dr. D. J. McCaa (p. 315); a case of recovery after ovariectomy, by Dr. S. T. Davis, (p. 317); a case of spinal bifida, by Dr. A. B. Blair (p. 414); and others

The reports and voluntary papers which precede the county society reports are especially full and of a high order of merit. It would give us pleasure to enumerate them, but the space at our command prevents us.

Transactions of the American Medical Association.

Vol. xxxi. Philadelphia, 1880.

This year the transactions make up a bulky volume of nearly 1300 pages. It is, we believe, the largest yet issued, and certainly it presents more numerous papers and more complete reports—taking the list of them—than any previous volume. The Sections are constantly rising in value as accessory bodies to the parent association. It is a satisfaction to add that most of the papers are such as merit preservation in this permanent form: most of them, we say, for few will deny that several of the articles are very lightly weighted with anything new or valuable, and at most, would deserve to see the light in some of the countless journals of the day. The pruning knife is visibly needed in the hands of the publication committee, or wherever it is that the grave responsibility of using it rests.

It would be a pleasure to specify a number of articles of exceptional interest in this volume. But, on noting them for that purpose, we find so many that it is better to recommend the reader to turn its pages for himself, for in whatever branch of the profession his interest especially centres, he will certainly find something to fasten his attention.

Much credit is due to the publication committee for the care and taste evident in the make up of the volume and its typographical display. All that involves an amount of dreary labor, of which the general reader has no conception.

A Manual for the Practice of Surgery. By Thomas Bryant, F.R.C.S., etc. Third American, from the third revised and enlarged English edition. Edited by John B. Roberts, A.M., M.D., etc. With 735 illustrations. Philadelphia. H. C. Lea's Son & Co., 1881. Half Russia, pp. 1005.

The intrinsic merits of Bryant's *Surgery* have led to a steadily increasing popularity, both in England and this country. He is a clear, compact writer, reminding one somewhat of Syme, and an operator of acknowledged skill and origi-

nality. Without freighting his book with multiplied details and wearying descriptions of allied methods of procedure, he is ample enough for reference on all the departments of surgery, not omitting such strict specialties as dental, ophthalmic, military, orthopaedic, and gynaecological surgery. Some of these chapters are written by specialists in these respective branches, and all are amply sufficient for any one not himself aiming at special practice.

The labors of the American editor deserve unqualified praise. His additions to the author's text are numerous, judicious and germane. They add very distinctly to the value of the original treatise, and give a more equitable illustration of the part taken by American surgeons than the author was able to do, owing to his less familiarity with our current literature.

The book is excellently printed, and as it can be had in the half Russia binding introduced by the publishers, its manufacture will satisfy the most critical.

Cyclopædia of the Practice of Medicine. Edited by H. von Ziemssen. Vol. ix. Diseases of the Liver and Portal Vein. With the chapter relating to Interstitial Pneumonia. Wm. Wood & Co. New York City, 1880.

This is the final volume of Ziemssen's Cyclopædia. The publishers are to be congratulated on getting through with it in a manner so satisfactory to their subscribers, and we trust, to themselves. It was a vast undertaking, with reference to cost and labor, and, as the publishers show in a circular, it has exceeded the original estimate by over 4000 pages.

As to whether an advantage to medical science in this country has been achieved, of corresponding magnitude to the commercial aspect of the enterprise, there is serious reason to doubt. The wordiness and theorizing of German writers, their tendency to dwell inordinately on insignificant points, and the distinctly speculative (using that word in its philosophical sense) character of their therapeutics, are traits that it would be unfortunate for us to adopt in the United States, and we hope the *Cyclopædia*, which is far from being free from these faults, will not have introduced them—at least, not to stay.

Nevertheless, it were vain to deny the vast amount of instruction contained in this great work, and we should be the last to do so. Recognizing it fully, we believe that, on the whole, such a translation is less useful than a judicious abridgment would have been. While we consider this the best of its kind, we hope the experiment will not soon be repeated.

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THE LIMITS OF A PHYSICIAN'S DUTY.

The physician who looks upon his calling as something more than a business recognizes that it, more than most, has to deal with important sociological questions. We familiarly call the defined result of various observations in physiology "Laws of Health." They are not laws in the forensic sense of that term, hardly so in its scientific sense, because on the one hand the government concerns itself but little with enforcing them, and on the other they are repeatedly disregarded without any injurious result following. Men daily expose themselves to draughts, sit in wet feet, or neglect their secretions, and escape any untoward consequences.

When it comes to matters of greater moment, where the evil is at any rate more conspicuous and the relation of cause and effect more apparent, the question arises how far ought the profession, as such, to advocate governmental interference. A living issue of this kind is the use of alcoholic drinks as a beverage. There is no difference of opinion that they do more harm than good; indeed, that they are a potent factor

in the physical degradation of a nation. Is it a part of our duty, as physicians, to express ourselves, as a body, against their manufacture and sale?

Take another subject, no less actively discussed in many quarters, the prevalence of prostitution. For a number of social reasons it appears to be on the increase in all our large cities. That it is a very fertile means of the extension of disease and greatly aids in the physical depravity both of the woman herself and those who patronize her trade, nobody denies.

What is worse in both these cases, the efforts which, in this country at least, have been made to diminish the evil consequences of liquor dealing and whoremongering, have been of little or no avail; less, perhaps, owing to any defect in the character of these efforts, than in the ability to carry them out honestly and systematically.

No doubt here, as in the false elocution of the players which Hamlet criticised, the proper way were to reform, not indifferently, but altogether. Can this be done by legislative power? Is it a part of the profession's duty to urge it on legislatures?

It is by no means clearly so. The tendency of all modern law-making has been against sumptuary enactments of every description. The uniform experience of history has proved them unsuccessful and inequitable. A decided majority should be willing to receive such a law and to aid in enforcing it before it is spread on the statute book. What is called the "interference theory of government," has few defenders among intelligent statesmen.

In all such examples we believe the activity of the profession has reached its limit when it enlightens the masses as to the danger of violations of health rules, and thus prepares the public mind to protect itself. Self-government, self-control, these are the true aims of all education, all government, and they alone are trustworthy guarantees of action.

In another direction the limits of a physician's action seems to require definition, that is, as toward religion. This is a delicate, a burning question, and we broach it with caution.

Nothing so quickly excites all a man's bad passions as to pinch his religious prejudices. But the inquiry is often made, and should be answered, how far a physician's religious views should enter into his avocation.

The editor of the *Edinburgh Medical Journal*, in a recent issue, expresses an opinion on the subject in the following language:—

The healing art takes precedence of all other human occupations. The clerical profession may occur to most minds as preëminent; but it is manifestly unable to cope with those disorders, bodily and even mental, to which our human flesh is heir, while, on the other hand, there is nothing to hinder the medical man, who does possess that power, to minister also, if he is at once religious and earnest, to the spiritual wants of his patients. Who, we would ask, gains and possesses the confidence of the dying man so thoroughly and rightfully as he who, with skill and sympathetic tenderness, has been attending to his bodily injuries and sufferings? We do not say that this possibility is actually realized so frequently, so systematically, as it ought to be, even by those who acknowledge it; but we hesitate not to aver that it exists, and even now may be seen in ample development, both in our own crowded cities and in many remote missionary fields.

We must express our dissent from the intimation of duty here conveyed. We do not think it any part of the physician's duty "to minister to the spiritual wants of his patients." We go further, and say that only in rare and exceptional cases has he any right to yield even to solicitation to do it, because he cannot do it honestly. The most any one can say under such circumstances is confined to bare and vague generalities. A physician of earnest religious convictions must utter them, if he speaks at all. Is he an ordinary Protestant, he will have patients who are Catholics, or Jews, or Unitarians, to whom any full expression of his religious consolations will be inapt and repellant. Does he himself belong to one of the other sects we have named, nothing he can say to an ordinary Protestant is likely to appear appropriate or agreeable.

In fact, nobody wants religious consolation other than the kind he has been accustomed to. Suppose the physician is a disciple of Comte, or Spencer, or Renan, or Bob Ingersoll; then the editor of the *Edinburgh Medical Journal* would readily excuse him from proffering the kind of

consolation those philosophers are prepared to dispense. So, we think, other folk, who have not the privilege of belonging to the kirk, will be quite willing to allow the physician to stick to his pills, the priest to his breviary, and the shoemaker to his last.

NOTES AND COMMENTS.

Metastasis in Mumps.

One of the most mysterious pathological sympathies is that of the parotid gland with the organs of generation. In the male, sympathetic orchitis is not rare; and in the female the whole generative system may be involved. Dr. Good says, "In advanced life parotitis is sometimes apt to run into a chronic form, accompanied by very mischievous symptoms. This is most especially apt to take place in females when menstruation is on the point of ceasing, and the general action of the system labors under some disturbance." Copeland, under the head of "Parotid Glands," adverts to the fact that parotitis, occurring in the female about the time of puberty, is apt to be very difficult to treat. Dr. S. Ringer, in Reynolds' *System of Medicine*, says that, "In the female, the mammae, the labia majora and uterus are the parts occasionally attacked." On the other hand, there are not wanting observations in gynecology to show that uterine disturbances give rise to inflammatory swelling and functional impairment of the parotid gland. After various operations on the uterus, parotitis sets in as a complication. The subject deserves closer study than it has yet received.

The Perivascular Lesions in Hydrophobia.

It is well known that some pathologists have maintained that certain perivascular lesions in the nervous system are characteristic of hydrophobia. Dr. Middleton, of Glasgow, lately stated to the Pathological Society of that city, that in two cases of hydrophobia he had found the perivascular lesion described by previous observers, and he had been led to examine the nervous structures in other cases, with a view to find out whether this lesion was in any way characteristic. Of twenty-four cases examined, fifteen showed this perivascular lesion, some of them in a form almost quite as marked as in hydrophobia. Sixteen cases had had more or less cerebral symptoms, delirium, etc., and only four presented no vascular lesion; among these were cases of fracture of the skull, erysipelas, delirium tremens,

diabetes, tubercular meningitis, uræmia, etc. The frequency of the lesion in so many diverse diseases was held to indicate that it could not be attributed to any special irritant in the blood, but rather to nervous excitement; and the investigations seemed to point to the fact that the intensity of the lesion varies directly with the intensity and duration of the cerebral excitement.

The results are published in full in the *Journal of Anatomy and Physiology*, October, 1880.

Hysteria in a Male Child.

MM. Bourneville and D'Oiller have published, in *Le Progrès Médical* for November 20 and 27 1880, an account of a case of hystero-epilepsy in a boy of thirteen, as a contribution to the study of hysteria in the male sex. This boy had hemi-anæsthesia of the right side, affecting the special senses, and partial color-blindness. There were numerous hysterogenic zones or areas, pressure upon any of which was followed by a fit. These fits were epileptiform, being preceded by an aura, and having their stages of tonic spasm, clonic spasm, and delirium. The boy's mind was never affected. Metallic bracelets and magnets caused transference of the hemi-anæsthesia, but could not effect a cure. Attempts to hypnotize him failed. He was cured by the douche.

Slow Development of the Physical Signs in Pneumonia.

An interesting debate recently took place at the Clinical Society of London. One member, Mr. Tyson, quoting Ziemssen's statement that up to the third day after the chill percussion over the affected part becomes dull and bronchophony appears, etc., said that such was not his observation. He added:—

"From my present experience of pneumonia, and seeing the disease as I do in its earliest stages, I believe that the physical signs, such as dullness on percussion, bronchial breathing, and bronchophony, occur later in the course of this disease than is usually supposed, or perhaps it would be more correct to say that there is a larger percentage of cases with the above lately-discoverable physical signs than our reading and teaching have led us to think."

Dr. Andrew Clark said that his desire was to enforce the impression that in a large percentage of cases the physical signs only became marked towards the close of the disease, when it had nearly run its course, and that consequently practitioners must, in coming to their conclusions, be largely guided by general indications.

Dr. DeHavilland Hall narrated some cases where for days the absence of physical signs had made him doubtful of their nature. He thought that those cases where the physical signs appeared late were more severe than those where they appeared earlier, having to spread from within the lung toward its surface.

It is well for all practitioners to remember that implicit confidence cannot be placed on the magisterial statements of many of these German writers. They have the national tendency to force facts into accordance with their theories.

Chorea in Pregnancy Treated by Dilatation of the Cervix Uteri.

At a late meeting of the Obstetrical Society of London, Dr. Wade reported an interesting case. An unmarried primipara, æt. 19, nearly seven months pregnant, suffered from very severe chorea, which had commenced in a slight form three weeks before admission. A faint apex systolic bruit, probably due to rheumatic fever two years previously, existed. An attempt was made to dilate the os with the finger, but owing to the incessant and violent movements of the patient, the success was very partial, and there was, if anything, an exacerbation of the symptoms. Three days after, under chloroform, the dilatation was completely effected; this was followed during the day by very marked amendment, and a sound night's sleep, the first she had had since admission, and every succeeding night was equally good. On the third day after the movements became worse than they had been on the two preceding days, and dilatation was again effected on the fourth day, under chloroform. From this time steady, rapid and unintermittent recovery supervened. A very slight occasional twitching of the fingers of the right hand continued until delivery, at term, of a healthy child, when they entirely ceased.

Hot Water Compresses in Tetanus.

Warm or hot baths in tetanus have frequently been found to give great relief; but in many circumstances it is practically impossible to give them. In view of this, in the treatment of tetanus and trismus, Dr. Spoerer has successfully employed hot-water compresses. He dips a large enough piece of coarse flannel in water of a temperature which can just be borne by the hand (50° to 55° C.), and applies the compress to the occiput and along the spine.

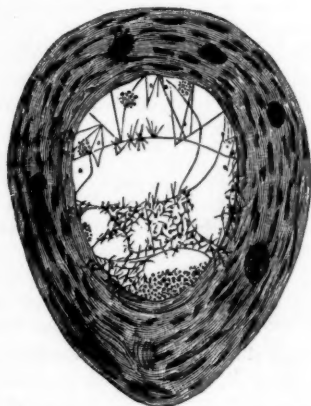
SPECIAL REPORTS.

V.—SYPHILOLOGY.

The activity in this branch is surprising, and we can give but brief analyses of a number of valuable papers which have appeared in the last few months. Beginning with etiology, we refer to

The Fungus of Syphilis,

or what is supposed by some to be such, as described and figured by Dr. Bermann, of Baltimore, in the *Archives of Medicine*, December, 1880. It is a variety of micrococcus, classified by Prof. Klebs with the *schizomycetæ*, but by Dr. Bermann with the *myxomycetæ*. It is represented in the following cut.



Section of an arteriole containing the branching fungus and spores found in chancres. Drawn from a preparation of Dr. I. Bermann, by Dr. R. W. Amidon. Objective $\frac{1}{2}$ Tolles.

The infection takes place by reason of a few germs of micrococci being retained in a lesion of the skin. They are taken up by the lymphatics, and here they increase and multiply, spreading principally in these, and soon begin to obstruct the circulation in them.

We shall refer later on to Dr. Bermann's theory of treatment, based on these observations. He is still pursuing his investigations, and we doubt not will obtain important results, both theoretical and practical.

The close relations of syphilis to profound impairments of the nervous system has recently attracted much attention. One of the most notable papers is on

Syphilis as the Cause of Locomotor-ataxia,

which appears in the *Medical Press and Circular*, Nov. 24th, Dec. 1st, from Dr. Thomas Stretch Dowse, Physician to the Hospital for Paralysis and Epilepsy, London. This writer has had

extensive opportunities for observation, and the decided statement with which he begins his article will surely surprise many. It is as follows:—

There can be no doubt, unless we have contrary proof of the most absolute and positive kind, that irregularity of movements and disturbances of volition, either in the engenderment of ideas or in the performance of coördinate muscular acts, are, in a very large majority of cases, due essentially to some syphilitic affection of the nervous centres. With this fact the clinical observer is becoming every day of his life more familiar, and it is a misfortune of the most serious nature to the patient when these symptoms and signs of incoördination are treated as mere trifles, and thought to be due merely to fatigue, or to stomach or liver derangement. I have no hesitation in making the statement that every case of locomotor-ataxia is curable, provided it be treated sufficiently early, and in the most energetic manner. Every case of locomotor-ataxy (with very few exceptions) can be traced to a syphilitic origin, if due care be taken to inquire carefully into the patient's history.

The pre-ataxic stage here referred to can be distinguished by the general symptoms of nervous break down; but there is one which is pathognomonic. Dr. Dowse says:—

Of these various signs there is only one upon which I place the most absolute reliance for a diagnostic point of view, and that is the fulgurating pains; and patients will often describe them to me, as though a fine lancet which had been made hot had been driven into the skin for about an eighth of an inch. These pains are not limited to the lower limbs; they may attack the head, the nose, the ears, the shoulders, the buttocks, and the scrotum, and even the penis, but as the disease advances and the ataxia becomes pronounced and decided, the legs alone are the seats of pain. I had a patient under my care a few months since who spoke of these pains as resembling the sting of a horse fly. These pains succeed each other with the greatest rapidity; they occur for the most part singly, and the patient has scarcely time to rub one part of the body before his attention is called to another part. Now these pains may be preceded and succeeded by intense itching over a limited and circumscribed area, and this state of itching will be as rapidly migratory as were the pains just described; and if we test the sensibility of the skin of the feet and lower limbs we shall find patches which are decidedly anæsthetic; but this is more particularly marked over the plantar and dorsal surfaces of the feet and inner part of the legs.

Another asserted etiological relation exists between

Syphilis and General Paralysis of the Insane.

While this has been frequently alleged, considerable doubt has been thrown upon it by Dr. Christian, in the *Union Medical Journal*, 1880. He gives notes of eight cases in which syphilis

and general paralysis were co-existent, and comes to the conclusion that anti-syphilitic treatment, however thoroughly carried out, only cures the syphilis, but has no power over the paralysis. Thus, Dr. Christian concludes that syphilis goes for nothing in the causation of general paralysis. Doubtless, in the complex etiology of general paralysis, it may be admitted that syphilis, as a debilitating constitutional disease, may be, in those predisposed, an accessory or secondary cause of the paralysis. Doubtless, also, syphilitic brain disease, which is very variable in its forms, may simulate more or less the symptoms of general paralysis, but it never appears as true general paralysis. Between the two, there is nothing in common. This is so true, that the disorders often progress side by side in the same patient without mixing, and *post-mortem* one finds, together with the alterations due to general paralysis, lesions peculiar to syphilis, such as gummata of the brain itself, or of its meninges.

This view is also supported by Dr. C. Drysdale, in the *British Medical Journal*, August 28th. He considers that syphilis is an occasional, though rare, cause of mania, dementia, and melancholia, but not of well-marked paralysis of the insane. In the majority of cases syphilis attacks the brain; it impairs the intellect more or less. Sometimes loss of intelligence is one of the first symptoms.

Syphilitic Neuralgia.

The substance now employed by Prof. Zeissl, in this form of neuralgia, is *iodoform* :—

R. Iodoformi, gr. xxij
Extracti gentianæ,
Pulveris gentianæ, aa q. s. M.

Make twenty pills. Two or three to be taken daily.

Syphilitic Jaundice.

Though not a frequent manifestation of the secondary stage, there is no doubt but that jaundice is occasionally directly due to the syphilitic poison. A very clear case is recorded by Dr. Soler y Buscalla, in the *Revista de Ciencias Medicas* for January, 1881. A youth of twenty-one years was admitted with swollen inguinal glands, cutaneous syphilides and a history of a primary chancre some months before. There were no gastric troubles nor febrile symptoms. Under a strictly anti-syphilitic treatment—protiodide and ferruginous syrup of quinia—the icterus disappeared. Dr. S. adds that none of the current explanations of syphilitic icterus are more than mere hypotheses, and it remains a pathological enigma.

Malignant Syphilis.

The existence of "malignant syphilis" seems clearly established—a form of the disease running its course rapidly and in spite of the most active treatment. A semi-malignant case is reported in the London *Medical Times and Gazette*, Dec. 18, from the London Hospital.

A man, fifty years of age, contracted syphilis in October. About the beginning of December ulceration attacked the left ala of the nose, and continued rapidly to spread until nearly the whole left side of the nose was involved, the lower portion of the right ala, and a considerable portion of the left cheek. When admitted, May 1, the left nasal bone and part of the upper maxilla were exposed, and all the surface named was sloughy and unhealthy. On the scalp there was a continuous cicatrizing surface from the centre of the forehead to the occipital protuberance, and a scar over the left temporal region. Patient was bald before the attack, so that these scars and ulcers were well seen.

Iodide of potassium was administered internally, and subsequently iron and quinine were given. Iodoform ointment was used as a local application. Under treatment the ulcers on the head rapidly healed, but at first the disease of the face was rather obstinate.

On May 18 it was noted that the ulcers on the scalp had quite healed, but that the phagedæna of nose and face had apparently extended. Iodoform powder was then dusted on these parts, and the wound assumed a healthier appearance.

Patient was discharged in the beginning of June, with the disease almost entirely arrested.

Syphilitic Diseases of the Lungs.

These have recently been studied by Prof. Gamberini, of Bologna, whose article appears in the *Gior. Ital. del. Mal. Ven.* His results are that the existence of a simple inflammatory syphilitic pneumonia may be admitted, but is not yet conclusively proved. The occurrence of a gummy form of disease of the lung is established beyond doubt. True pulmonary tuberculosis may be associated with syphilis, but it preserves always its own pathological characters. To distinguish between the syphilitic and the tubercular forms of lung affection, the author proposes for the former the title of "consumptive pulmonary syphilis." The influence of specific treatment is, at the present time, the best therapeutic means of diagnosis between tubercular and syphilitic disease of the lung. Prof. G. agrees with Schnitzler, that pulmonary disease as a consequence of late general syphilis, or even of acute secondary syphilis, is not a rare occurrence. Laryngeal lesions often precede or accompany syphilitic pulmonary affections. This has been proved by the observations of Schnitzler, who, indeed, affirms that the diagnosis of syphilitic lung disease may be made by means of the laryngoscope alone. The symptoms

of syphilis of the lung are generally those of pneumonic phthisis, from which, during life, there may be no certain means of distinguishing it; even after death, the distinction cannot always be made between gumma and tubercle, especially when the gummy nodules are in a state of caseation, or are infiltrated. Syphiloma most usually spares the apex, whereas tubercle most frequently attacks that portion of the lung. This, however, is not constant, as has been shown by Fournier. The course of pulmonary syphilis is usually slow and apyretic, which is not usually the case in tubercular phthisis. Syphilis, also, is accustomed to attack only one lung, and one part of the lung. This tendency to localization is considered by the author to be a very important point in the diagnosis of pulmonary syphilis, whether the lung be attacked at an early or at a late stage of the disease.

Syphilitic Iritis.

This much feared complication requires prompt action. The treatment recommended by Mr. J. R. Wolfe, surgeon to the Glasgow Ophthalmic Institution (*London Medical Times and Gazette*, January 1st), is as follows:—

After the administration of pil. hydr. c. colocythidis, I order small doses of ol. terebinth—one teaspoonful three times a day in syrup. aurantii. It was recommended by Dr. Carmichael, and was the favorite remedy of Dr. M'Kenzie. This I continue for three or four days, with warm drinks, foot-baths, etc. Then I order pil. hydr. c. quinae three or four times a day, and the unguent. hydr. fort., into the armpit, 3j. every evening; warm baths twice a week. When the gums begin to get tender, I discontinue the pills, and only apply the unguent. hydr. to the axilla, and internally potassium iodide is ordered. Should symptoms of mercurialization supervene, I discontinue the ointment and keep the patient exclusively to potassium iodide, which may be given ʒj. three times a day. The strong atropine solution, with the gray ointment, is continued for a considerable time. The drops may even be persevered with for a month after the general inflammatory symptoms have disappeared.

Syphilitic Gummata of the Iris.

The latest study of this subject is by Dr. E. Nitot, *Des gommés syphilitiques de l'Iris et du Corps Ciliaire*, Paris, 1880. His discussion leads to the following results:—

Every malignant tumor of the ciliary body in a syphilitic subject should be considered as a gumma. Every malignant tumor of the ciliary body in a non-syphilitic subject is probably either a melano-sarcoma or a tuberculous tumor. Although a gumma is destructive, and in this sense malignant (heterologous), it can usually be dissolved by iodide of potassium, and is not liable to

return. Gummata of the iris are much more frequent than those of the ciliary body, and yield readily to anti-syphilitic remedies.

Gummy Tumors.

The subject of syphilitic affections of the eye, especially gummy tumors, is also discussed by Dr. C. Arago, in the *Revista de Ciencias Medicas*, January 1881. He especially calls attention to the importance of an early diagnosis, and of their treatment by improved pharmacal methods. Mercurial fumigations he considers injurious and dangerous. He slightly salivates with fractional doses of calomel supported by infusion of jaborandi, and maintains it by such a combination as—

R	Protiodide of mercury,	10 centigrams,
	Iodide of potassium,	8 grams,
	Water,	300 grams. M.

A spoonful with a few mouthfuls of infusion of jaborandi two or three times a day.

Very decided improvement is visible after a week or two of this treatment, and a complete cure is sure to be effected.

Syphilis as a Cause of Cataract.

The eminent ophthalmologist, Professor GALEZOWSKI, advanced the opinion, in the *Recueil d'Ophthalmologie*, Sept. 1880, that syphilis may cause cataract in the adult primarily, or predispose to it hereditarily. He gives details of a case of kerato-irido-choroiditis in a child of four years of age affected with syphilis from its birth. In this case, a cataract became developed, and the eye was enucleated. The author has seen, in all, nine cases of congenital cataract in children born of syphilitic parents. As regards the effects of syphilis in the adult, he has frequently seen cases of monocular cataract affecting an eye in which there was syphilitic choroiditis, while in the other eye the lens was perfectly transparent. He gives details of a case of syphilitic choroiditis attacking one eye, followed by the development of soft cataract six months afterwards in the other.

In passing to the subject of treatment we may first mention

Treatment of the Primary Sore.

Dr. Bermann, in the article above mentioned, recommends that the fungi be destroyed by *hypodermic injections of mercurials*. He says of them:—

When properly made, these injections are not painful, and never produce abscesses unless the syringes are unclean. Even in cases where a quick mercurialization had to be resorted to (for instance, in iritis specifica, where the gumma was touching the membrana Descemetii), I have had

the most perfect results with them, never observing any relapses nor producing salivation. At the same time, we are thus enabled to derive the full benefit from any other kind of medicine (such as iron, etc.) given by the mouth, and do not run the risk of disturbing gastric digestion by giving mercury internally.

The plan of *excising the sore* recommended by various German surgeons, was reviewed in the *Annales de Dermatologie*, last July, by Dr. Chadzynski. He reported thirty cases from his own practice. The part was first washed with a solution of carbolic acid (3 or 4 per cent.). The induration was next laid hold of with the fingers or forceps, and, under the spray, the whole indurated portion was removed. Sutures were then inserted, according to the size of the wound, and carbolic lotion or iodoform applied. In only six of the thirty cases did primary union take place. In five, induration reappeared, but the cicatrix sometimes remained free from hardness, even after the appearance of secondary symptoms. Seven cases were successful, sixteen were unsuccessful, and, in the remaining seven the result was unknown, owing to the disappearance of the patients. Of the successful cases (those in which there were no signs of constitutional syphilis), two were kept under observation for six months, three for seven months, one for thirteen months, and one for more than twenty-four months. In all the seven there was more or less enlargement of the corresponding lymphatic glands at the time of the excision of the sore.

It must be acknowledged that this result does not encourage one to rely on the operation.

Syphilitic Ulcers.

Good success has been obtained by Vidal in obstinate syphilitic ulcers by the following:—

R. Acidi pyrogallici, 1 part.
Ung. petrolei, 5 parts. M.

It succeeded when other measures failed, and also acted well on chancroids. It causes slight pain for five or ten minutes (*Archives of Dermatology*, Oct. 1880).

As a final resort the *thermo cautery* may be employed; we quote the following very interesting case from the *Glasgow Med. Journal* for January, 1881, from the Glasgow Royal Infirmary:—

John Riley, a shoemaker, was admitted to Ward XIII on 16th May, with an ulcer on the lower lip. The history of the case showed that he had contracted syphilis three years before, and had suffered from the usual sequelæ. He was treated by a medical man for some time. Shortly after the treatment was discontinued an ulcer appeared on the lip, but this healed up perfectly on the treatment being resumed. Again, after a few months the lip broke out and gradually be-

came worse, notwithstanding the use of the anti-syphilitic remedies which had proved efficacious before. This went on for two years, treatment being resorted to at intervals. On admission, there was observed an ulcer somewhat excavated, the edges raised, hard, and evoked, discharging a fetid pus, and exquisitely painful, extending over the whole of the outer surface of the lower lip. The patient had a dusky, ill nourished, syphilitic look, and the inguinal glands were hard and rolling. He was put upon iodide of potassium, with bichloride of mercury, and a lotion of chloride of zinc was applied to the sore. At the end of a fortnight there was not the slightest improvement, when Dr. Danlop had the patient put under chloroform, and destroyed the surface thoroughly with the thermo-cautery. After this, pain was never complained of, and the sore healed up kindly. The bichloride and iodide were still continued and a simple water dressing applied.

He was discharged 25th June, perfectly cured. This case is an example of a syphilitic sore taking on a certain degree of local malignancy, so that it resisted all ordinary treatment for that disease, and yielded readily on the destruction of its surface.

Syphilitic Psoriasis.

As it occurs on the palms of the hands and soles of the feet, is generally very obstinate and resists mere constitutional treatment. A writer in the *Lyon Medical* recommends that preparations of *corrosive sublimate* should be painted once or twice daily on the papules, pustules, and crusts, after bathing the parts; compresses of solution of acetate of lead will lessen pain and prevent irritation. For lesions in the soles and palms, the best excipient in which to prescribe the sublimate is collodion; for tender parts of the skin and for the slighter manifestations of syphilis, alcohol; for lesions of the mucous membrane, ether.

Very obstinate palmar or plantar psoriasis should be painted every morning with an application consisting of one part of corrosive sublimate, one of fresh linseed oil, and fifteen to twenty-five of collodion. In the evening the parts should be energetically rubbed with white precipitate ointment (one part of ammoniated mercury to five of simple ointment).

In cases marked by deep fissures and considerable infiltration, local baths with a 2.5 per cent. solution of carbolic acid, or a five per cent. solution of chloride of potassium or sodium, or rubbing with zinc ointment or sparadrap de Vigo, will be found useful.

Turpentine as an Anti-syphilitic.

Some interesting experiments with this are detailed in the *London Medical Times and Gazette*, Dec. 11, 1880, by Dr. B. Nicholson. A soldier had been treated by iodide of potassium for a syphilitic plaque below Poupert's ligament.

Freed from all appearance of disease, he was, after due caution, discharged with three days' convalescence. Almost immediately, however, after his return to duty, he re-appeared before me in the same state as at first. On this I changed the treatment, and gave him half a drachm of turpentine thrice a day, made into an emulsion with water and liquor of potash. Under this he rapidly got well, was discharged, and did not return.

Of course, I was led to give turpentine a more extended trial in buboes, suppurating and non-suppurating, and in syphilitic orchitis, etc., but without effect. Some two or three years afterwards I was shown, by a medical friend, one case of plaque, and another of syphilitic orchitis, both of which had resisted treatment. I narrated my experiences and turpentine was tried. The plaque case got well; the orchitis remained unaffected.

I took charge of a man recovering from the last of several relapses of *syphilitic iritis*. He had been somewhat profusely salivated, and the salivation continued. Before it ceased he had another relapse. I gave one-drachm doses of turpentine, using belladonna or atropine locally. The result was a speedy cure. Afterwards, the salivation having ceased, he had another attack. Turpentine was given, but without effect, and I was obliged to have recourse to mercury, under which he recovered. In other and more ordinary cases I did not find turpentine of any use.

Bichromate of Potash in Obstinate Syphilis.

In those obstinate cases whose progress cannot be checked by the ordinary remedies, Dr. F. Arpal recommends the bichromate of potash (*La Union Medica de Aragon*, Nov. 1880). He begins this potent poison in doses of one centigram daily, in an opiate vehicle, cautiously increasing it to four centigrams daily. He has observed relaxation of the symptoms in four or five days, and a complete restoration to health follow. These were cases of undoubted and progressing syphilis, which were not benefited by mercurials or iodide of potash.

In discussing the theory of its action, he believes that it is through its powerfully oxidizing agency that it alters the condition of the system. It is also a decided anti-zymotic, and may destroy the syphilitic fungus.

CORRESPONDENCE.

Medical Matters in Vermont.

State Medical Society Meeting; Legislature Regulating the Practice of Medicine and Surgery; State Board of Health; Comments on Dr. Corson's Article.

ED. MED. AND SURG. REPORTER :—

The Vermont Medical Society holds two meetings during each year. The annual meeting is always held at Montpelier, the Capital of the State, and on the second Wednesday and Thursday

of October. The semi-annual is held in different parts of the State; last year at St. Albans, this year at the city of Vergennes. Both meetings are quite largely attended from all parts of the State, though the interest of the profession in them is not what it ought to be. The meeting at St. Albans was interesting, on account of the excellent papers that were read and the discussions that followed. Diphtheria and typhoid fever are fruitful subjects for discussion, and always call out an immense amount of theory which shows a wider difference of opinion than exists in practice. The therapeutics of these diseases and their kindred are better understood, or there is more general agreement upon methods of treatment than upon the cause which produces the disease. All agree that, to a large extent, they may be prevented by proper sanitary and hygienic regulations. This session of the society was attended by the professors and students of the Medical Department of the University at Burlington, and Professors Settle and King read very interesting papers. Dr. J. H. Warren, of Boston, read a paper upon the method of curing hernia by hypodermic injection of the hernial ring, and performed the operation upon a patient before the Society. The operation was completely successful. Dr. Warren explained fully his method of performing the operation, and communicated the formula for the substance injected.

The annual meeting for 1880 was held during the session of the Legislature. Four years ago an Act regulating the practice of medicine and surgery was passed by the Legislature, which was fairly satisfactory to the profession, including the Homœopaths and Eclectics. Censors were appointed by all the State Medical Societies, and as a result a large class of itinerating quacks were driven from the State, not having, nor being able to obtain, a license to practice medicine in the State. Two years ago, through the lobby influence of this class, and their friends in the Legislature, an amendment of the Act was passed, which practically opened the door for the re-admission of the whole horde of quacks into the State. And they have improved the opportunity. The law being thus practically nullified, the State Medical Society petitioned the Legislature to repeal the law. And it was done at the last session. An effort was made at the late session to enact a law more stringent than the one repealed, and similar to that of New York, and perhaps, of other States. It met with the most furious opposition, mainly from the Homœopaths and Eclectics, very few of whom have a diploma from any Medical College of any kind. It was ably advocated in the House, where it originated, but failed to pass. Another two years of quackery in the State will, we trust, so change the tone of public sentiment on this subject that the passage of a law requiring at least some show of knowledge of medicine and surgery in the practitioner, will be a popular demand. Till that time passes, quackery will have full swing all over the State. It is fair to say that some members of the profession in the State have no confidence in such legislation. They would prefer to have the fraternity stand upon its own merits, raise the standard of preliminary and medical educa-

tion, and guard the door into the profession against the admission of any one who is not thoroughly qualified in all its branches. The Medical Department of the University at Burlington is taking high ground upon this subject, and to its credit, it is becoming widely understood that no novice or ignoramus in academic or medical education can pass the severe ordeal of its examination. With such schools for medical instruction in all the States, the profession will ere long occupy a much higher vantage ground than it now does, and suppress quackery by the force of superior education.

For several years past efforts have been made to establish a State Board of Health and Vital Statistics. Two years ago the bill passed the Senate unanimously, but was lost in the House. In the last Legislature it passed the House by a large majority, but was lost in the Senate, ostensibly for want of time to consider it, the bill reaching that body late in the last evening of the session, but really, if we are rightfully informed, for reasons not quite so reputable to honorable Senators. It was on this wise. The bill was advocated with great ability and earnestness in the House, by several of its most prominent members. One member, in his zeal, overstepped, perhaps, the bounds of debating courtesy, and declared that no man of common sense would vote against the bill. This, with other remarks still more pointed, gave offence to certain Senators who happened to be in the House during the debate, and who, on returning to their seats in the Senate, passed the word around the chamber that the House was attempting to "bulldoze" the honorable Senate into the passage of the Health bill. When the bill reached the Senate the fever was at its height, and the bill was "indefinitely postponed." The Senate of Vermont is usually the conservative, deliberative branch of the Legislature, but it did not maintain its usual reputation in that direction this year. The friends of a State Board of Health for Vermont are not discouraged. They feel confident that another session of the Legislature will accomplish the object, and place the Green Mountain State in line with other States of the Union in the grand work of preventive medicine.

I have just read, with pleasure and profit, the first installment of Dr. Corson's article in the *REPORTER* of Jan. 15th. The views of pneumonia he presents are worthy of consideration. In the early part of my professional life I was in the practice of blood-letting for every disease that assumed an inflammatory type. The practice then was to bleed in fevers, and especially in pneumonia, and to follow the bleeding with purgative doses of calomel and jalap in the former, and with tartar emetic in the latter. Some were cured, of course, or got well, but many died. In later years I have adopted a different course. I have laid aside the lancet, not discarding its use, but holding it as a kind of *corps de reserve*, to be used when necessity demands. In its stead I now use *veratrum viride*, sometimes alone, and sometimes with *aconite* and *morphia*, one or both. The first stage of pneumonia, in my opinion, is congestive, not inflammatory; that comes as a sequence of failure to control the congestion. Take the symptoms Dr. Corson mentions in his

typical case. Instead of bleeding, as he suggests, I would prescribe *veratrum viride* in tinct. or fluid extract, with *aconite*, and I should expect before the patient had taken many doses of it his pulse would come down from a hundred to seventy, and perhaps fifty; he would breathe freely; his flushed, anxious face, as if suffocation were imminent, would have disappeared; his cough would be subdued; perspiration would break out all over him, and in a few days' time he would be about his daily avocation, having lost but little of his strength or vitality; bounding up from the deep depression of a threatened fever or inflammation. Having tried both methods of practice faithfully, I am satisfied that more patients can be saved from the jaws of death by *veratrum* than by the lancet. It is very seldom that I have a case of pneumonia in my practice. With the treatment I pursue they seldom reach that stage, and if they do, the disease is arrested before it reaches the next stage. L. C. BUTLER, M.D.

Essex, Vt., Jan., 1881.

NEWS AND MISCELLANY.

Registration of all Practitioners of Medicine.

A bill carefully prepared, and approved by leading members of the profession, having this object in view, is now before the legislature of Pennsylvania. Copies of the report of the committee on Medical Legislation, read before the State society, at its last meeting, have been laid on the desks of the members of both Houses, and the following memorial, as well as petitions have been presented:—

To the Honorable, the Senate and House of Representatives of the Commonwealth of Pennsylvania, in General Assembly met:—

The undersigned memorialists, being the officers, the permanent members and the delegates, at the last meeting of the Medical Society of Pennsylvania, respectfully represent that the Act approved March 24th, 1877, entitled "An Act to protect the people of the Commonwealth against incompetent practitioners of Medicine. Surgery and Obstetrics," has failed to accomplish the important objects aimed at.

The Legislature of the State of New York, at its last session, passed an act requiring all persons who practice medicine or surgery to register in the office of the clerk of the county in which the practitioner resides. In like manner the Legislature of the State of New Jersey, at its last session, passed an act requiring each practitioner to file a copy of his or her medical diploma in the office of the clerk of the county, and on failure of this to abandon the practice of medicine.

What your memorialists especially desire at present, is, that an act may be passed which shall provide for the registration of all practitioners of medicine, irrespective of the so-called schools of practice, as in all European countries, the Canadian provinces, the South American States, and in some of our own States. Experience has shown that incompetency, deception and fraud can be more easily prevented by this

means than by any other. The legal profession, after an examination, requires all its members to register under oath or affirmation, and there appears to be no good reason why provision should not be made for the medical profession in Pennsylvania.

In conclusion, your memorialists beg leave to ask your attention to the Report of the Committee on Medical Legislation, read before the Medical Society at its last meeting. And we will ever pray, etc., etc.

Information on this subject may be obtained through the chairman of the Committee,
R. L. SIBBET, *Carlisle, Pa.*

Improvement in Florida.

An important enterprise, with the object of reclaiming South Florida, has been started.

The drainage of Lake Okeechobee, contracted for by the authorities of Florida, will, if successfully accomplished, result not only in the reclamation of the bed of the Lake itself, but, it is believed, in that of the two vast swamps known as the "Everglades" and the "Big Cypress," which lie south of the Lake, and cover the greater portion of the lower end of the peninsula. The "Everglades," sixty miles in length, and about the same in width, really constitute a vast lake, from one to six feet in depth, studded with thousands of small islands.

As the extreme southeastern portion of Florida has legitimate claims, as a health resort, over any portion of the State, the sanitary value of this scheme deserves the attention of physicians.

The Philadelphia Dispensary.

The secretary of this excellent institution says, in the course of a letter in the *Public Ledger* :—

"The beneficent objects of this institution in behalf of the deserving poor,—to treat the sick who are curable and "to make the path to Heaven easier" for those who are not—were never better carried out than at this time. And should any Christian man or woman feel it in his heart to give or bequeath a fund of say ten to twenty thousand dollars to the Philadelphia Dispensary, the income to be awarded, according to the rules and judgment of the Board, to the physicians who toil and day and night in its service without material reward of any kind, it would be a practical recognition of their deserts greatly to be desired."

It certainly would be a most meritorious action, and we hope the secretary's words will not fall unheeded.

The Smallpox Epidemic.

This dreaded disease has assumed the proportions of an epidemic in various parts of the country. In this city the deaths are about sixty per week. In Danville, Pa., the public schools have been closed on that account. It is reported to be "making terrible ravages" in Bellechasse and Dorchester Counties, Quebec. In Chicago, ten to fifteen new cases daily were reported to the Health authorities. In the penitentiary at Fort

Madison, Wis., contract work is abandoned, on account of the number of cases in the institution. Jefferson, Dakota, has been surrounded with a "shot gun" quarantine; out of ninety cases thirty-two were fatal. The railroad authorities forbid trains to stop there.

These are only a few of the numerous items of the kind in the daily papers.

Cremation in Rome.

A warm discussion took place recently, in the Municipal Council, relative to the official recognition of cremation. A petition had been received from the Society for promoting this method of disposal of the dead, asking permission to erect a furnace and other necessary appliances in the public cemetery. A good deal of sentiment was, of course, imported into the matter by several speakers, but finally, chiefly owing to the clear and temperate address of Dr. Baccelli, the motion to grant the request was carried by a substantial majority. Cremation, therefore, is now legalized at Rome, as at Milan, Florence, and other towns.

Humanized Vaccine Virus.

At the request of various correspondents, we have arranged to supply those who wish it with humanized vaccine virus, in the shape of scabs. They are obtained from healthy white children, and are guaranteed fresh and active. Price \$1.50 and \$2.00, according to size.

The deaths from smallpox in this city numbered, last week, 61, a decided increase on the average of the last month.

Trichinae in a Cat.

Living trichinae, says the *Pathologist*, have been recently found, at the pathological laboratory of the Long Island College Hospital, in the muscles of a cat which had "died from natural causes" and been brought to the laboratory for dissection. The animal was emaciated and icteric. Placed on a slide, in a neutral solution, the trichinae kept up a spiral, vermicular movement for several hours.

Confessions.

A correspondent writes: Your new departure in inviting the profession to publish errors as well as successes is a capital idea, and it is to be hoped that it will elicit many responses. If it does not, it will not be owing to the scarcity of the article. I have a dim recollection of having committed one or two myself, "in the early years of my practice," as the fathers say.

Items.

—Positively the last of General Washington's servants died last month, in Washington. This was Sally Hunter, who was one of the slaves manumitted in his will. She was born—so it is said—on his estate, in 1766, and hence was 115 years old. It is about time for these famous freedmen to become extinct.

—The annual report of the Board of Health of Chicago shows that there were 10,462 deaths in that city during 1880, out of a population of 503,298. This shows a death rate of 20.79 per 1000.

—There was a man in Indiana who paid a highly promising oculist \$10 for so treating his eye that he could see as well by night as by day. The operation was perfectly successful, for now the man cannot see at all.

—The New York Board of Health has passed an ordinance making it a misdemeanor, punishable by a fine of \$25, to hold public or church funeral services over any person who dies from a contagious or infectious disease, such as small-pox, diphtheria, scarlet fever, yellow fever, typhus fever, or Asiatic cholera.

—Dr. Octave Pavy, the Guldare's surgeon, who remained in Greenland with Henry Clay, of Louisville, when the Guldare returned home last fall, writes that he intends to go north by water next summer, to deposit provisions at different points, intending to start north with dogs and sledges the winter after, and he is hopeful that he may reach a high enough latitude to settle the question of an open polar sea.

OBITUARY NOTICES.

—Dr. George Taylor, of New Milford, Conn., died recently, aged 79 years. He was the oldest homœopathic practitioner in the State, and the first, in 1837, to introduce the doctrines of Hahnemann. He graduated at the Yale Medical School in 1824.

—Dr. Samuel T. Knight, a well known physician, died Wednesday night, Jan. 19, at his residence, No. 112 North Greene street, Baltimore, in his sixty-fourth year. He was a practicing physician in that city for over 40 years. He served one term and part of another as Health Commissioner.

—Dr. George Ferrel, member of the West Virginia House of Delegates from Berkeley County, dropped dead at his boarding-house in Wheeling, Feb. 2. He was in the House on Monday, and was taken slightly ill just before adjournment, but nothing serious was apprehended. His disease was announced as spinal apoplexy.

—Dr. Charles Winterburn died in New York last week. He was born in Yorkshire, England, 65 years and 9 months ago. He came to this country in 1840, and went to Cincinnati, where he practiced medicine till 1865. He then removed to New York, and followed his profession until his death on Sunday morning, January 20. He was found dead in bed, when called for breakfast, having died of paralysis of the heart.

—George W. Hewitt, M.D., died at his residence, in Franklin Grove, Lee Co., Ills., Wednesday evening, January 12th, aged 50 years. He was born in Middleburg, Franklin Co., Pa. His medical studies were pursued under Dr. Samuel Chew, of Baltimore, and at the same time he attended lectures at the University of Maryland, where he graduated in 1854. On the first of May of the same year he located at

Franklin Grove, and pursued the practice of medicine until within a few months of his death. During the late war he served as Brigadier Surgeon under General Kirk. He was an active member of the American Medical Association, and attended many of its meetings. He was a member of the Masonic fraternity, and was buried under the auspices of Dixon Commandery, No. 21, on Sunday, January 16, 1881.

QUERIES AND REPLIES.

Dr. R. B. G., of Tenn.—The best work on Dietetics for children is, probably, "Jacobi's Infant Diet," price 75 cents.

Dr. W. E. H., of Pa.—A microscope good enough for all ordinary clinical purposes, can be bought for \$40 or \$50.

Dr. Michel.—1. There is no unanimity of opinion among the physicians of this city, as to the relation of typhoid fever to sewer gases. 2. The mortality of the disease is supposed to be about 14 per cent. 3. The cold bath treatment is not in vogue here.

Dr. S. K., of Ga.—We are not aware of any cases of tapeworm having been supposed to have been derived from extracts of beef. The thing is not impossible, but is certainly unlikely.

Pharmacist, Pa.—The subject of the relations of pharmacists to physicians is just now being actively discussed in this city, and with a fair prospect of benefit to both parties.

MR. EDITOR.—If Dr. Lavery, of Middletown, Pa., will put his patient on fluid ext. ergot, and fluid ext. jaborandi, equal parts, and give teaspoonful doses three or four times daily, I think he will reduce the quantity of urine rapidly, and excite a proper action on the skin. He can reduce the quantity of jaborandi, and increase the ergot, if circumstances require. Should he use it, let us hear the result. J. M. KELLER.

Hot Springs, Ark., January 22, 1881.

MARRIAGES.

ASHENFELTER—ROYER.—On Jan., 20, 1881, by the Rev. C. W. Schaeffer, D.D., at the residence of the bride's father, W. G. Ashenfelter, M.D., of Pottstown, Pa., and Isabella, daughter of Stat. Senator Lewis Royer, of Trappe, Pa.

LOVEJOY—DUNTON.—In Germantown, Pa., on the 19th inst., by the Rev. W. J. Chichester, assisted by the Rev. S. C. Hill, Rev. W. W. Lovejoy, M.D., of Boston, and Miss Emma Dunton, of Germantown.

DEATHS.

ARROTT.—In this city, on the 24th inst., Dr. Colin Arrott, in the seventieth year of his age.

BUGBEE.—In Waterford, Vt., Jan. 11, Dr. Ralph Bugbee, in his 85th year.

DARRACH.—At Germantown, Pa., on Friday evening, January 28, William Darrach, M.D.

LIPPINCOTT.—At Salem, N. J., on Seventh-day morning, the 22d inst., Dr. A. B. Lippincott.

PARSONS.—In this city, suddenly, on the 21st inst., of paralysis, Dr. John B. Parsons, aged 45 years.

RAMSEY.—In this city, suddenly, on the 27th inst., A. M. Ramsey, M.D., in his 36th year.

WINTERBURN.—In New York, suddenly, Sunday morning, January 21, 1881, Charles Winterburn, M.D., formerly of Yorkshire, England.